THE ROLE OF HEALTH SECTOR BASKET FUND ON IMPROVEMENT OF HEALTH SERVICES PROVISION: A CASE OF NACHINGWEA DISTRICT COUNCIL, LINDI REGION

By

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A Dissertation Submitted in Partial/ Fulfillment of The Requirements for Award of the Degree of Master in Research and Public Policy of Mzumbe University.

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled "**The Health Sector Basket Fund on improvement of health services provision in Nachingwea district council**" in partial fulfillment of the requirements for award of the Master degree in Research and Public Policy of the Mzumbe University.

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I, **Ngoma T. Mbago** declare that, this dissertation is my own original work and that it has not been presented anywhere and will not presented to any other Institution for a similar or any other degree award.

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DEDICATION

I dedicate this work to my beloved father and mother as a memory for their love, care and efforts done for my education from childhood to this level. I would also like to dedicate this dissertation to my lovely wife, Devotha P. Ngoma, my three sons Brian M. Mbago, Davis P. Mbago, Ethan N. Mbago and lastly my only beloved daughter Noreen K. Ngoma, for their encouragement and patience during my study.

LIST OF ABBREVIATION

AIDS	-	Acquired Immune Deficiency Symptoms
BMGF	-	Bill and Melinda Gates Foundation
BOD	-	Burden of Diseases
CCHP	-	Comprehensive Council Health Planning
CHMT	-	Council Health Management Team
DACC	-	District Aids Control Coordinator
DC	-	District Commissioner
DDO	-	District Dental Officer
DED	-	District Executive Director
DHFF	-	District Health Facilities Financing
DHIS	-	District Health Information System
DHS	-	District Health Secretary
DHO	-	District Health Officer
DLT	-	District Laboratory Technology
DMO	-	District Medical Officer
DNO	-	District Nursing Officer
DP	-	Development Partners
D Pham	-	District Pharmacist
DRCH – co	-	District Reproductive Child Health Coordinator
DSWO	-	District Social Welfare Officer
EU	-	European Union
FY	-	Financial Year
HCP	-	Health Care Provider
HF	-	Health Facilities
HHS	-	Hospital Health Secretary
HIV	-	Human Immunodeficiency Virus
HSBF	-	Health Sector Basket Fund
LGA	-	Local Government Authority
MDG	-	Millennium Development Goal
MMR	-	Maternal Mortality Rate
MoU	-	Memorandum of Understanding

MTEF	-	Medium Term of Expenditure Fund
MoHCDGEC	-	Ministry of Health, Community development, Gender, Elderly and Children
NHP	-	National Health Policy
NSGPR	-	National Strategy for Growth and Poverty Reduction
PPP	-	Public Private Partnership
(PRRINN – MNCH)	-	Partnership for Reviving Routine Immunization in Northern Nigeria – Maternal, Newborn and Child Health.
RAS	-	Regional Administrative Secretariat
RHMT	-	Regional Health Management Team
SPSS	-	Statistical Package for Social Science
STD	-	Sexual Transmission Disease
SWAP	-	Sector Wide Approaching Program
UFMR	-	Under Five Mortality Rate
UNFPA	-	United Nation Fund for Population Activities
UNICEF	-	United Nation International Children Emergency Fund
URT	-	United Republic of Tanzania
WHO	-	World Health Organization

ABSTRACT

The study examined the implementation of Health Sector Basket Fund on improvement of health services provision in Nachingwea District Council. The study specifically, examined the trend of Health Sector Basket Fund disbursement for financial years, 2015/2016, 2016/2017 and 2017/2018, determined the activities supported by Health Sector Basket Fund implementation as planned in the Comprehensive Council Health Planning, and determined the perceived challenges of Health Sector Basket Fund implementation in the Nachingwea District Council.

The study employed a single descriptive study design comprising the sample size of sixty (60) respondents including council health management team, health facilities in charges and their assistants. Moreover, simple random samplings were used as selection technique of the study. A quantitative research approach was employed in this study to collect information from the respondents easily and timely. The data collection tool used was a questionnaire which involved both closed and open ended questions. The descriptive statistics analyses were done with the aid of Statistical Package for Social Science (SPSS) version 21.

The major findings of the study showed that, the trend of HSBF disbursement in three financial years 2015/16, 2016/17 and 2017/18 were Tsh. 401,727,651.87,Tsh. 503,277,000.00 and Tsh.428,394,800.00 respectively. The amounts were disbursed in two phases that is a half in every two quarters until the amount was finished and the results indicate that the council did not receive the Health Sector Basket Funds (HSBF) timely, and that the fund was sent to the council on quarterly system. That means, half of the budget needed for two quarters and another half of the amounts was received for the other last two quarters. The results also show that, the activities supported by Health Sector Basket Funds (HSBF) were implemented as planned in the Comprehensive Council Health Planning (CCHP). It also shows that, the major challenge in the implementation of Health Sector Basket Funds (HSBF) were delay in disbursement of funds and transport system. The study recommends that, the Health Sector Basket Fund (HSBF) improve the health services provision in Nachingwea Ditsrict Council. The government should insist the partners and donors who support the fund to disburse timely in order to rescue the consequences of health services provision in all councils.

Key word: Basket Fund; improvement; health services provision; Nachingwea

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CHAPTER ONE
BACKGROUND INFORMATION

1.0 Introduction

The chapter explains the background of the study, statement of the problem, general objective of the study, the specific objectives of the study, the research questions, and significance of the study, Limitations of the study, Definition of the key terms, Communication framework and Theoretical frame work.

1.1 Background of the Study

Since the late 1980s, many developing countries have initiated efforts to improve their health systems. A number of factors prompted these efforts was the most from state controlled economies to Market oriented economies. Insufficient funding for health in times of financial crisis, lack of basic health services for many citizens and poor quality of health services, low accountability and inefficiency of existing health services were the main problem affecting health sector. To address the issues many governments launched health sector reforms, which are intensive long term efforts to strengthen and improve health systems and ultimately, improve the nations' health sector (WHO, 2000).

The Health Sector Basket Fund was also practiced in Bolivia and Netherland. Bolivia was receiving fund to support Health system from Netherland as one of the bilateral Country from European Union (UE). Minister of Foreign Affairs and the State Secretary for Foreign Affairs of Netherland, decided to reduce the number of partner countries in supporting the health sector from 33 to 15 in order to decrease the fragmentation and increase specialization which enhanced effectiveness of Dutch bilateral aid (Ankita *et al*.,2015).

In Nigeria, the Health Sector Basket Fund (HSBF) started at state of Zamfara and Kano for Primary Health Care (PHC) in 2009 and 2013 respectively. Other states such as Banchi and Yobe established their own fund, three years later in 2012.The Kano basket fund was a tripartite agreement between Kano State, the Bill and Melinda Gates Foundation (BMGF) and Dangote Foundation, a philanthropic arm of the Dangote Group.

A report by the URT (2013) reveals a number of factors, which affect the implementation of health sector activities under various sources of funds. In accordance with the URT (2009), the evolution of health sector basket fund goes back in 1991, where the government of the United Republic of Tanzania decided to introduce what was termed regulated private practice in 1991 as a result of unfavorable economic situation experienced in 1980s.Hyden, (1980) noted that, soon after independence, the United Republic of Tanzania introduced a policy on free medical service to his entire citizens. Arusha declaration (1967) came with a component of free care to all citizens and the government banned all private service providers who were for profit in 1977 (Kolstad & Lindkvist, 2013).

The Health Sector Basket Fund was incepted as the result of the decision made by the Ministry of Health (now Ministry of Health, Community Development, Gender, Elderly and Children) and Development Partners (DP). Health Sector Basket Fund initiated in 1999 as part of Government decision to pursue a Sector Wide Approach (SWAP) in the health sector reform. The Sector Wide Approach Programme (SWAP) was aiming in increasing coordination among donors and government, supporting one health sector programme. The Basket Funds aiming at making systemic improvements and increasing government ownership (URT, 2009).

The Funds by a number of Development Agencies pool un-earmarked resources to support the implementation of the Health Sector Strategic Plan III. The Basket Fund was created as a pooling mechanism of donor's resources to support Decentralization by Devolution (D by D) which means transfer of decision making power to local government authorities and implementation of the National Health Strategies on Mainland Tanzania (Ankita *et al*.,2015).

In the early 1990s, the Tanzania Government strained for providing free health c**a**re for all became evident in the face of rising health care costs and a struggling economy. The government adopted health sector reforms that changed the financing system from free services to mixed financing mechanisms under Cost Sharing policies. The Cost Sharing in the form of user fees was introduced in four phases. Phase I was from July 1993 to June 1994 to Referral and some services in Regional Hospital. Phase II was from July 1994 to December 1994 to Regional Hospitals. Phase III was from January 1995 onwards to District Hospitals and Phase IV

introduced to health centre and Dispensaries after completion of introduction to all District Hospitals (WHO, 2000).

Despite the fact that, the introduction of cost sharing and funds collected were used in the budget of health services provision, the funds were not enough to fulfill the gap facing the health facilities like medical supplies, drugs and availability of other medical materials and equipments for health services provision. In the Local Government Authority (LGA), expenditures on health and the fragmented delivery of Primary Health Care (PHC) between State and Local agencies have led to inefficient use of limited resources. The unreliable funding flow had disrupted multiple facets of Primary Health Care (PHC) delivery and contributed to unfavorable situations. Alleviating financing problems is a step towards improving the quality and delivery of Primary Health Care (PHC) programs in the state (Ankita *et al*, 2015).

Approximately, 80% of the population of Tanzanian lives in rural areas. The early studies on cost sharing in Tanzania, found that access to health care declined significantly as a result of introduction of user fees programme in public health facilities (World Bank Report of 2001). Most of Tanzanian population faces the difficulties in accessing health services, due to lower income accrued from agricultural activities and livestock keeping. For this reason, they fail to afford the cost sharing which led to increase morbidity and under five mortality rates. The introduction of Basket Fund channeled directly to the District level where it is allocated according to local needs and demand helps to reduce the rate (WHO, 2000).

The government of Tanzania signed a memorandum of Understanding (MoU), by all parties which set out the roles and responsibilities between development partners in supporting the Basket fund mechanism. The Health Sector Basket Fund (HSBF) represents a significant source of funding for the District (Joint Annual Health Sector Review, 1992). The intention of the government to the sign Memorandum of Understanding (MoU) was to support the implementation of a decentralized responsibility for health services to Tanzania Local Government Authorities to reach a more efficient and effective use of aid resources (Mushi, 2014).

In Local Government Authorities, Health Sector Basket Fund is mostly used in Health sector to support primary health care and other health services to be delivered efficiently at the community levels. It also serves to improve the Health Sector

Strategic Plan IV (2015 – 2020), to support the achieving service delivery targets by linking quality of services and governance to performance payments. The current seven development partners contributing to the Health Sector Basket Fund are Canada, Denmark, Ireland, Switzerland, and United Nation Fund for Population Activities (UNFPA), United Nation International Children Emergency Fund (UNICEF) and World Bank. Channeling resources through such a modality confirms a commitment towards a more effective and efficient use of aid resources, that is, in line with both the Paris declaration and the aspiration of the Tanzania Government as elaborated in the Joint Assistance Strategy (Mushi, 2014).

Nachingwea District Council is among of the councils within the Lindi Region which received the Health Sector Basket Fund. In the financial year of 2015/2016 the council received the Health Sector Basket Funds of Tsh.401,727,651.87, in the financial year of 2016/2017, the Council received Tsh.503,277,000.00 and in the financial year of 2017/2018, the Council received Tsh.428, 394,800.00. Although the Council received fully Health Sector Basket Fund budgeted for each financial year, there is delaying of the disbursement of the funds from the central government to council levels and the amount received by the council is distributed quarterly from the central government for three consecutive financial years of 2015/2016,2016/2017 and 2017/2018. In addition, other challenges include inadequate implementation of supportive supervision and working environment in the health facilities, inadequate procurement and distribution of medical drugs, equipments and supplies, insufficient water and sanitation, delay in disbursement of funds from the central government to the council level for three consecutive financial years of 2015/2016, 2016/2017 and 2017/2018 for primary health care. Malaria prevalence rate of Nachingwea District Council is 30% higher than the region prevalence rate of 11.7%. Lindi Region has high malaria prevalence rate of 11.7% compared to the National prevalence rate of 7.3%. Under five mortality rate (UFMR) is also high 36/1000 live birth rate compared to National rate of 67/1000 live birth rate. This shows that in Lindi Region the rate is low compared to the national rate. The amount budgeted for Malaria prevalence rate was Tsh.16,000,000.00 in 2015/2016, Tsh.22,000,000.00 in 2016/2017 and Tsh.18,800,000.00 in 2017/2018, while under five mortality rate the Council budgeted Tsh.17,000,000.00, in 2015/2016,Tsh.19,000,000.00, in 2016/2017 and

Tsh.15,000,000.00 in 2017/2018 (Source: CCHP 2015/16,2016/17,2017/18 & DHIS of Nachingwea Council of 2015/16, 2016/17, 2017/18).

1.2 Statement of the Problem

The introduction of health Sector Basket Fund (HSBF) aimed at improving health services delivery, yet much has not been revealed as to whether the aim has been achieved or not. The Health Sector Basket Fund (HSBF) was initiated in 1999 as a part of government decision to pursue a Sector Wide Approach (SWAP) in the health sector. The government signed a Memorandum of Understanding (MoU) by all parties, set out the roles and responsibilities between development partners in supporting the Basket Fund mechanism. The fund was un-earmarked resources to support the implementation of Health Sector Strategic Plans.

The aim of the Health Sector Basket Fund (HSBF) is to support the implementation of decentralized responsibility for health services to Tanzania Local Government Authorities to reach a more efficient and effective use of aid resources. The fund is used in Health sector for supporting Primary Health Care and other health services to be delivered efficiently to the community levels in Local Government Authorities. Some of the health services provisions have been well improved due to the introduction of the funds.

Despite the fact that, the basket fund is playing a big role on improvement of health services, in addition, its implementation, challenges facing the fund, disbursement mechanism and activities carried over under the fund have not been well known. Due to the disbursement of funds targeted in the Local Government Authorities health facilities, there is a delay of funds from the Central government to the council level.

There are few studies have been done on the fund (Ankita et al., 2015, Joint Annual Health Sector Review, 1992, Mushi, 2014) particularly in Nachingwea District Council. According to the Comprehensive Council Health Planning (CCHP) of financial year, 2015/16, 2016/17 and 2017/18,District Health Information System (DHIS) of 2017/2018, this delay of funds from the central government to council level has led to insufficient implementation of planned activities to council which contribute to un- improvement of health services like insufficient supportive supervision and working environment in the health facilities, insufficient distribution

of medical drugs, equipments and supplies, insufficient water and sanitation, unchanged prevalence rate of malaria for three years consecutively as compared to other diseases conditions, unchanged under five mortality and maternal mortality rate overtime.

Therefore, the aim of this study was to examine the implementation of Health Sector Basket Fund to ascertain whether it is implemented as indicated in the Comprehensive Council Health Planning (CCHP).

1.3 Objective of the Study

1.3.1General Objective

The general objective of this study was to examine the implementation of Health Sector Basket Fund (HSBF) on improvement of health services provision in Nachingwea District Council.

1.3.2 Specific Objectives

The study was guided by the following specific objectives:

i. To examine the trend of Health Sector Basket Fund disbursement for the financial years 2015/2016, 2016/2017 and 2017/2018;
ii. To determine the activities supported by Health Sector Basket Fund which is implemented as planned in the Comprehensive Council Health Planning; and
iii. To determine the perceived challenges of Health Sector Basket Fund implementation in Nachingwea District Council.

1.4 Research Questions

i. What is the trend of Health Sector Basket Fund disbursement for the financial year of 2015/16, 2016/17 and 2017/18?
ii. What are the activities supported by Health Sector Basket Fund implemented as planned in Nachingwea district council?
iii. What are the perceived challenges of Health Sector Basket Fund implementation within the Council?

1.5 Significance of the Study

The study will enable the government and development partners to be aware of the extent to which the funds implemented in the improvement of health services provision within the council level. The study will help in implementing health care activities in the district and other district councils in the country especially in addressing the challenges affecting the implementation of health care services under Health Sector Basket Fund, and in the improvement of quality of health services to be provided in the Health facilities to the societies.

1.6 Scope and Delimitation of the Study

The study examined the implementation of Health Sector Basket Fund (HSBF) on improvement of health services provision in Nachingwea District Council. It specifically focused on examining the trend of Health Sector Basket Fund (HSBF) disbursement for the financial years 2015/2016, 2016/2017 and 2017/2018, determining the activities supported by Health Sector Basket Fund which are implemented as planned in the Comprehensive Council Health Planning, and determining the perceived challenges of Health Sector Basket Fund implementation in Nachingwea District Council. The selection of this area was based on the fact that Nachingwea is one among the six (6) district councils within the Lindi Region which submitted their quarter technical financial reports earlier, but received the Health Sector Basket Funds (HSBF) late compared to other districts. The study could not be conducted in all district councils in Tanzania due to limited resources in terms of finance, time, labor and materials.

1.7 Limitation of the Study

The researcher encountered some limitations in the course of data collection; some of the respondents were reluctance in filling in the questionnaire on time, the researcher had to go to some respondents more than once to pick up the questionnaires. Some respondents were so busy with other official activities which in somewhat contributed to the delay in filling in the questionnaire timely. Despite these challenges or rather limitations, the researcher managed to behave patient in order to get the information from the respondents. Other respondents who were busy with other duties, the researcher manage to visit the respondents more than once to pick the questionnaires in order to collect sufficient and reliable data for this study.

1.8 Theoretical Framework

The theory which governs the study is the theory of Health Impact Assessment (Scott, 1998). Scott accepted that, the health of a population is determined by a range of factors and the greatest scope for improving the public health lies outside the control of the National Health System. Health Impact Assessment has emerged to identify those activities and policies likely to have major impacts on the health of a population.

Health Impact Assessment theory is seen as a universal decision support tool, applicable at all political administrative levels. It explores in detail and use at a local level. It is a decision support tool sensitive to the determinants of health inequalities. The intention of the theory is to support decision making in choosing between options and to predict the future consequences of implementing the different options. The aim is to profile the population affected by proposal, for example, to identify vulnerable groups (Barnes & Scott, 2002).

The theory is important for addressing population health and health inequalities because it tackles health determinants. It has become a common belief that, health is determined largely by factors outside the health care sector (Kenum, 2006). In Local Government Authorities, Health Sector Basket Fund is mostly used in health sector to support primary health care and other health services to be delivered efficiently to the community levels. Most of the councils depend on Health Sector Basket Fund for procurement of health equipment, accessories, and medical drugs, paying extra duties and allowances to health workers. Referral systems from the lower to higher level medications, conducting supportive supervision and minor rehabilitation to health facilities. The fund is disbursed from the central government to the Local Government's levels and the Regional level acts as supervisor of the council's levels, collection of the implementation reports and advice the council health management team on what to do to overcome the challenges facing the health facilities within the council levels (Kenum, 2006).

Since, the theory of Health Impact Assessment bases on supporting decision making in choosing between options and predicting the future consequences of implementing the different options, it applies and relates to the point of the outcome after implementing the activities funded by Health Sector Basket Fund. The Health Impact Assessment is important for addressing population health and health inequalities because it tackles health determinants. It has become a common belief that, health is determined largely by factors outside the health care sector (Kenum, 2006).

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter deals with literatures related to the study. It includes both theoretical and empirical literature review.

2.2 Theoretical Literature Review

2.2.1 Health care financing

Health care financing is a branch of finance that helps patients and health care beneficiaries pay for medical expenses in the short and long terms. It based on function of a health system concerned with mobilization, accumulation and allocation of money to cover the health needs of individually and collectively people in the health system. The purpose of financing is to make funding available when needed as well as to set the right financial incentives to providers. It also deals with ensuring all individuals have access to effective public health and personal health care (WHO, 2000).

Good health financing system raises adequate funds for health, in ways that ensure people can use needed services and protected from financial catastrophe associated with paying when services needed suddenly. Health care financing provides incentives for providers and users to be well efficient and consistence to all organizations, people and actions whose primary interest is to promote, restore or maintain health (WHO, 2010).

2.2.2 Health Sector Basket Fund

In Tanzania, the home grown version of the Primary Health Care (PHC) was largely shaped by the post- independence nationalistic policies that from the very beginning identified three enemies of development namely, ignorance, diseases and poverty. After Arusha Declaration in 1967, very momentous especially followed the pronouncements that formed the cores. The Primary Health Care (PHC) programme was implemented as a response to this policy framework. The strategy was perceived as an engine to fight poverty and bring an inclusive development for all Tanzanians. To increase coverage of health services equally to all who are in need, the country committed itself to a policy of providing free health care services at the point of use.

By the late 1970s and early 1980, Tanzania experienced economic and social crises, with profound implications for financing and delivery of social services (Munishi, 2003; Kumaranayake *et al*, 2000).

The Health Sector Basket Fund was incepted as the result of the decision made by the Ministry of Health (now Ministry of Health, Community Development, Gender, Elderly and Children) and Development Partners (DPs). The aim of introducing of the Health Sector Basket Fund is to enable the Tanzanian people to have an access of receiving quality of health services which were not provided by the private sector in the rural areas. The Private sector based on urban areas only in provision of health services due to the higher income earned by people living in urban areas.

Health sector Basket Fund is a funding mechanism initiated in 1999 as part of the Government of Tanzania's decision to pursue a Sector Wide Approach Program (SWAP) in health sector. The mechanism of pooling funds from various sources, typically governments, donors and the private sector, to support priorities and ensure adequate resources allocation for agreed upon program areas is the concern. The fund was created in 1999 as a pooling (fund) mechanism of donor resources to support decentralization by devolution (transfer of decision making power to local government authorities) and the implementation of the National Health Strategies on Mainland Tanzania. It pools donor and government funds to pay for long term improvement in the health sector and supports the implementation of the Health Sector Strategic Plan IV (2015 - 2020).The overall aim of the Health sector Basket Fund is to increase financial resources in the health sector, with a focus on Local Government Authorities (LGA), in order to reach underserved populations with essential, effective and affordable health services and to contribute to effective decentralization to enhance delivery of quality primary health care (URT, 2009; Christian, 2007).

2.2.3 The role of Health Sector Basket Fund

In 2007, the government of the United Republic of Tanzania has programmed as one of the renewed efforts to effectively engage the health sector in poverty reduction strategies. The connection of health sector in poverty reduction efforts has been well established in various government policy documents and the development literature. Not much is known in Tanzania about the contribution of the Primary health care

programme to meet the National Strategy for Growth and Reduction of Poverty (NSGPR) targets in particular and the Millennium Development Goals (MDGs) in general. Inadequate funding is another problem that has featured in almost all the reviewed policy documents. The shortage has compounded the existing problem of inequities in accessing and utilizing health care services whereby the poor and vulnerable groups are the most affected. Important also is a narrow window of enforcing Public Private Partnership (PPP) in financing and delivery of health care services. Evidence provided indicate that private health facilities are concentrated in Urban areas while more than 70% of Tanzania population reside in rural areas with higher burden of poverty, diseases and other public health problem (Chatora & Tumusimwe, 2003).

The Funds play a crucial role in the devolution of health services responsibility to the local government authorities and for the set up of comprehensive and participatory district level health planning, budgeting, monitoring and reporting. It plays the role in supporting the provision of primary health care services through funding central level Medium Term of Expenditure Fund (MTEF) to purchase essential drugs and commodities, to support the programmers in reproductive and child health, Nutrition, Immunization, Malaria, Human Resources Development and Strengthening Referral Hospitals, Zonal training centers, Chief government Chemist. It also plays the role of supporting the meaningful implementation of decentralization of responsibility for health services to Local Government Authorities (Christian, 2007).

2.2.4 Limitation of Health Sector Basket Fund

Perhaps, Basket funds support only recurrent expenditures; it is strictly prohibited to be using in paying sitting, special, subsistence and honorarium allowances for Council Health Services Board (CHSB), Council Health Management Team (CHMT), and Health Facilities Governed Committees (HFGC) routine meetings. The funds also should not be used to pay statutory allowances such as uniforms, leave, medical refund, burial, acting, subsistence allowance and responsibility allowances for any public servants. Also, strictly not to be utilized in cleanness of towns, municipal, cities, councils and other activities out of health services to the communities. The guideline restricts the reallocation of approved funds to be used to other activities out

of planned activities. The guideline also restricts expenditure for allowances, transport and minor repair /maintenance to go beyond 20 percent of the total approved budget.

2.2.5 Percentage Limits of funds allocation

The Health Sector Basket Fund is allocated basing on the population of 60 percent, poverty count of 10 percent, land capped area of 10 percent and \Under Five Mortality (UMFR) of 10 percent. The Comprehensive Council Health Planning (CCHP) guideline stipulates the boundaries in which the Health Sector Basket Fund (HSBF) should confirm as per suggested cost centers. District Medical Officer (DMO) Office 15 – 20 percent, Council Hospital 25 – 30 percent, Voluntary Agency Hospital 10 – 15 percent, Health Centre 15 – 20 percent, Dispensaries 20 – 25 percent and Community level 2 – 5 percent.

2.2.6 Health facilities

A health facility is an institution for health care typically providing special treatment for impatient (over right) stays. The place where provides health care for those clients need the services. The location where the health care is provided and range from small clinics and doctors' offices to urgent care centers and large hospitals with elaborate emergency rooms and trauma centers. The health facilities include Hospital, Clinics, Outpatient care centers and specialized care centers. The number and quality of health facilities in a country or region is one of the common measures of that area's prosperity and quality of life. In many countries health facilities are regulated to some extent by law and licensing by a regulatory agency is often required before a facility may open for business. Health facilities may be owned and operated for profit business, non – profit organizations, governments and in some cases by individuals, with proportions varying by country. The workload of a health facility is often used to indicate its size. Large health facilities are those with a greater patient load according to Health Organization (WHO, 2006).

2.2.7 Comprehensive Council Health Plan

Comprehensive Council Health Plan is an annual health and social welfare plan for the council that collates the health and social plans at all levels and involve all stakeholders supporting the funds within the council level. The stakeholders are supposed to be involved to see what are the priorities of the council and what should have based on supporting the situation in order to meet the required needs of the

councils. The stakeholder's priorities should correlate with the council's priority as well (URT, 2011).

2.2.8 World Health Organization (WHO)

World Health Organization (WHO) is a health system acting synergistically to improve health of the people, increase responsiveness to social and financial risks protection, and improves efficiency of health care systems. They include services delivery, health workforce, health information system, access to essential medicines, financing and leadership governance (WHO, 2010).

2.2.9 Health services provision.

Health services Provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of a series of interventions or health action. Services delivery systems are responsible for providing health services for patients, persons, families, communities and populations in general but not only caring for patients. Services delivery system should also consider the whole spectrum of care from the promotion and prevention to diagnostic, rehabilitation and palliative care as well all levels of care including self care, home care, community care, primary care, long term care, hospital care, in order to provide integrated health services throughout the life course. Health care is the maintenance or improvement of health via the prevention, diagnostic and treatment of disease, illness, injury and other physical and mental impairments in human beings. It is delivered by health professionals (Providers or practitioners) in allied to health fields controlled by World Health Organization (WHO, 2000).

2.3 Status of Health Services Provision before Health Sector Basket Fund in Local Government Authorities.

Before introduction of Health Sector Basket Fund, the government of Tanzania ensures the health services are available and accessible to all people in the Country, in both Urban and Rural areas. All may lead to reduce the burden of disease, maternal, an infant's mortality and increase life expectancy through provision of adequate and equitable maternal and child health services. Since independence in 1961, the government has consistently focused its development strategies on combating ignorance, diseases and poverty. The investment in primary health services is recognized as a potential tool in fighting diseases and at the same time improving the

quality of lives of majority of the people. Before outlining the challenges facing the primary health services, perhaps, it is, important to understand the general information in which primary health services are placed. The information is on country's geographical features, administrative structure, current population characteristics, socio-economic situation, health status, Organization and management of health services and the present status of primary health care services (Carrin, 2005).

In 2007, the government of the United Republic of Tanzania launched the Primary Health Care (PHC) services development programme as one of the renewed efforts to effectively engage the health sector in poverty reduction strategies. The connection of health sector and poverty reduction efforts have been well established in various government policy documents and development literature, not much is known in Tanzania about the contribution of the primary health care programme in meeting the National Strategic Growth and Poverty Reduction (NSGPR) targets in particular and the Millennium Development Goal (MDG's) in general (Chatora & Tumusimwe, 2003).

The National Health policy based on the objective of free health services to all citizens within the country aims at reducing the Burden of Disease (BOD). Malaria remains to be a major cause of morbidity and Mortality both in rural and urban areas. It ranks number one according to inpatient and outpatient statistics. It is also a major cause of death for children aged below five years and inflicts a huge burden due to anemia, especially in pregnant women. In recent years, the pattern of malaria has dramatically changed expanding into areas previously known to be malaria free. Also there has been an increase in number of cases and deaths due to Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) and Tuberculosis. Health outcome indicator shows that life expectancy at birth for Tanzania is on average of 63yrs (URT, 2013) compared with 50yrs (URT, 1988), probably attributed to effects of the Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS). Under Five Child Mortality is on declining trend from 147 per 1000 in 1999 to 112 per 1000 in 2005 and infant mortality rate has declined from 99 per 1000 to 68 per 1000. Promising the level is unacceptable if compared to developed countries. Maternal Mortality Rate has

remained high. In 1996, Maternal Mortality was 529 while in 2005 was 578 per 100,000 live births (Carrin, 2005).

The Primary Health Care (PHC) programme was implemented as a response to this policy framework. The strategy was perceived as an engine to fight poverty and bring an inclusive development for all Tanzanians. To increase coverage of health services equally to all who are in need, the country committed itself to a policy of providing free health care services at the point of use. By the late 1970s and early 1980s Tanzania experienced economic and social crises, with profound implications for financing and delivery of social services (Kumaranayake *et al*., 2000).

The public health facilities were operated with dismal provision of health care and people want to pay for some improvement. Such arguments are augmented by prevalence of acute resource gaps and inability of the fiscal system to rise adequate funding for the health sector. The early impact of the user fees on quality of and access to public health care show mixed results with general indication that attendance in public health facilities decreased. The government of Tanzania introduced user fees at the hospital level in the mid 1990s in line with popular arguments for fees in sub District level health facilities. A number of issues with regard to gains and losses from user fees are still unresolved. It is not yet clear whether cost sharing is generating the anticipated impacts in terms of quality improvement and universal access to basic quality health care at the primary level, particularly by those deemed vulnerable to such fees. Access to health care services refers to the number or proportion of people reporting for medical attention in health care facilities. Utilization of health services refers to the number or proportion of the consulting patients that give medical services including medical consultation. Poverty is commonly measured in the form of indices. In absolute terms the proportion of a given population is said to be poor if they fail to meet the expenses of the commodity bundles defined as a necessary consumption to live the minimum standard life in a given economy. Anonymously, food poor people are those unable to afford the basic calorific inputs defined as necessary for human being survival in given particular economy (Carrin, 2005).

The objective of the National Health Policy was to ensure that all people in the country are receiving the health services free of charge. The availability of drugs,

reagents and medical supplies and infrastructure are being financed through typical tax base and large informal sector, donors from the westerns countries and international trade. Inadequate funding is another problem that has featured in almost all reviewed policy documents. The shortage has compounded the existing problem of inequalities in accessing and utilizing health care services whereby the poor and vulnerable groups are the most affected. There is an adequate financial resource for procurement of drugs, reagents and medical supplies due to insufficient budgeted amount of funds. In order to address the problems, the government refers the population of the country. It is difficult to provide free health services for all citizens within the country while the economic growth is still low. The government is not independent in terms of economic factors concerning resources especially financial resources. It depends on tax base and large informal sector, donors, income tax and assets taxes and international trade, which are not enough to afford the purchasing of medical facilities for provision of free health services to all people (URT, 2001).

The government insisted collection of taxes and improving the international trade was supposed to be subjected with another funding budgeted in order to meet the required needs. The existing in adequate financial resources is due to weak income of people and assets taxes collection, the economic situation of citizen low production and income generation. The donors also come with condition that, since the poverty of the country is ongoing process, the government should review the policy of providing free health services to all citizens within the country and on top of that, people should contribute for their health services provision. The shortage has compounded the existing problem of inequities in accessing and utilizing health care services whereby the poor and vulnerable groups are the most affected. Important also is a narrow window of enforcing public private partnership in financing and delivery of health care services. Evidence indicates that, the private health facilities are concentrated in urban areas while more than 80% of Tanzania population resides in rural areas with higher burden of poverty, diseases and other public health problems (Chatora & Tumusimwe, 2003).

2.4 Empirical literature review

Most of researches have shown that, there is improvement of health services provision through the Health Sector Basket Fund in Sub- Saharan countries in Africa.

According to Ankita *et al*, (2015), the contribution of Health Sector Basket Fund in health services provision, the funds address barriers to primary health care financing, resulting from inconsistent prioritization of health, weak budget implementation and lack of transparency and accountability in the use and allocation of public resources. The early experiences from two states in Nigeria, Zamfara and Kano, indicate that basket fund help, to ensure availability of funds to implement primary health care plans and also enhance accountability while creating transparency in how, when and where funds are disbursed. Through political feasibility it can be challenging with advocacy and political will, two states in Nigeria, Zamfara and Kano, successfully established basket funds for Primary Health Care (PHC) in 2009 and 2013 respectively. The Zamfara experience became a model of successful Primary Health Care financing and motivated Kano to establish a basket fund. Other states such as Banchi and Yobe are in the process of setting up their own funds. The development of the Zamfara basket fund was spearheaded by the Partnership for Reviving Routine Immunization in Northern Nigeria-Maternal Newborn and Child Health Initiative (PRRINN-MNCH) a program supported by the United Kingdom Department for International Development. Operational zing Zamfara basket fund took approximately two years. Achieving consensus on the basket fund budget was a lengthy process. The government financed approximately 80% of the basket fund budget and supplemented the remaining and operational expenditures for routine Immunization. Both Zamfara and Kano basket funds were structured around a robust priority setting the budgetary process, guided by an expenditure and disbursement allocation plan and protected by a system of checks and balances. With time and success, basket funds have the potential to address primary health care financing in Nigeria and other developing countries facing similar challenges.

Another study of Basket fund improvement of primary health care conducted also in 1992 in Nigeria. The National Primary Health Care Development Agency (NPHCDA), a parastatal of the Federal Ministry of Health in Nigeria, was established for the single purpose of improving the country's primary health care system. Policies are formulated and adopted by National Primary Health Care Development Agency (NPHCDA) at the federal level and implemented by the Local Government Authorities (LGAs) of each state. When Local Government Authorities (LGAs) received financial autonomy in the 1980's by extension, they also became the

principles funding source for Primary Health Care (PHC) services delivery. Policy makers believed that, increased proximity would enhance the government responsiveness to local needs and improve the quality of Primary Health Care (PHC) services delivery within its jurisdiction. However, contrary to expectation, three goals remain far from being realized today. Over the years, the state of Primary Health Care (PHC) has gradually deteriorated with shortages in financing lying at the core of the delivery challenges. Inadequate transfer of resources to Local Government Authorities (LGAs) and poor transparency and accountability in how Local Government Authority (LGAs) priorities, allocate and release funds for Primary Health Care (PHC) has constrained health facilities frequently operating without adequate financial resources and are unable to provide basic Primary Health Care (PHC) services as required by National Primary Health Care Development Agencies (NPHCDA). In addition, challenges with poor documentation of state and Local Government Authority (LGAs) expenditure on health and the fragmented delivery of Primary Health Care (PHC) between state and local agencies have led to inefficient use of limited resources. The unreliable funding flow has disrupted multiple facets of Primary Health Care (PHC) delivery and contributed to unfavorable health outcomes (Ankita *et al*., 2015).

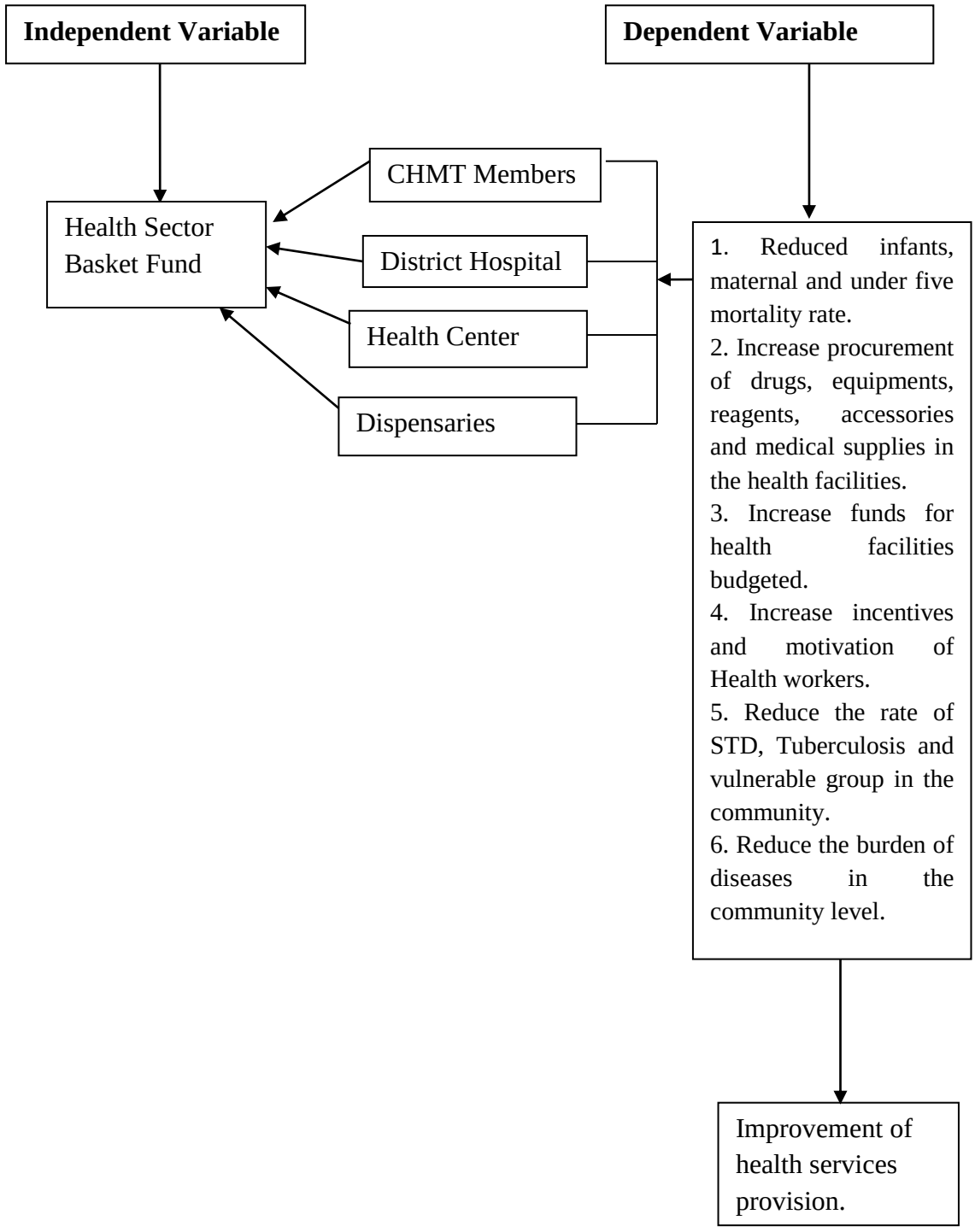
Due to the failure of National Health Policy Strategy of Tanzania to operate free health services provision to all citizens of Tanzania, the donors also come with condition that, since the poverty of the country is ongoing process, the government should review the policy of providing the free health services to all citizens within the country and people should contribute for their health services provision. Later the government decided to change is policy system of health services provision from free of charges to contributions in order to fulfill the gap of inadequate financial resources for procurement of drugs, reagents and to other medical equipments and supplies in his health facilities. The policy of cost sharing and paying for health services is practiced in urban areas where most people may afford to pay for health services due to income generating activities. In rural areas where most Tanzanians are found failure to afford payment of health services is due to low income generated from their source namely agriculture. The shortage has compounded the existing problem of inequalities in accessing and utilizing health care services whereby the poor and vulnerable groups are the most affected. Although, the cost sharing plays the role of

contribution in health services delivery to every citizen within the country, still other health services like supportive supervision and working environment in the health facilities, distribution of medical drugs, equipments and supplies, malaria, mortality, water and sanitation, and other primary health care have become a major cause of morbidity in rural and urban areas. It ranks number one according to impatient and outpatient statistics. It is also a major cause of death for children aged below five years and inflicts a huge burden due to anemia, especially in pregnant women. In the recent past the pattern of malaria has dramatically changed expanding into areas previously known to be malaria free. Also there has been an increase in number of cases and deaths due to Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and Tuberculosis. Health outcome indicator shows that life expectancy at birth for Tanzania is on average of 50yrs, National Population & Housing survey census 11 URT (1998) attributed to effects of the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS). Under five child mortality was 147 per 1000 in 1999. The problem of financial resources due to insufficient budgeted amount of funds for procurement of drugs, reagents and medical supplies, still exist and increase growth rate of inadequate financial resources due to economic situation of the country.

2.5 Conceptual Framework.

On the basis of the above literature review, the conceptual framework of this study hypothesized the improvement of health services provision as a dependant variable that is determined by Health Sector Basket Fund as an Independent variable. The aspect of the fund is to help the local government authorities where the 80% population of Tanzanian are found, to improve the primary health care and equitable health services provision within the communities' level. The introduction of the fund was to ensure that, the health services are available and accessible to all people in the country in Urban and Rural areas. All these may lead into reducing the burden of disease, maternal and infant's mortality and increase life expectancy through provision of adequate and equitable maternal and child health services. The conceptual framework can be illustrated in the figure below;

Figure 2.1 Conceptual Framework



Source: Modified from Researcher, 2015.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains how the study was conducted. It includes research design, research approach, area of the study, sampling techniques and sample size, the targeted population, methods of data collection and data processing and analysis.

3.2 Research Approach

The researcher used a case study method and quantitative research approach in the study to get information from respondents in order to test whether the role of Health Sector Basket Fund, contributed on improvement of health services provision.

3.3 Research Design

In this study, a cross- sectional and descriptive research design was employed. The cross sectional research design was used for observations and interpretation of the entire population at once on specific point of time and the descriptive research design was employed to get general description of the respondents. The process of data collection from each Health facilities in Nachingwea District Council was conducted once at a point of time.

3.4 Study Area

The study was conducted at Nachingwea District Council in Lindi Region. Nachingwea District Council is in the North West part of Lindi Region. It has a total of forty-one (41) Health facilities of which three (3) were Hospitals, two (2) were Health centers and thirty six (36) dispensaries. Among those Hospitals, one was owned by the Government, another by mission and the remaining by the Army. Four dispensaries were owned by private and the rest by the government. The reason for conducting this study in this area was Nachingwea is one among the six (6) district councils within the Lindi Region which submitted their quarter technical financial reports earlier, but they received the Health Sector Basket Funds (HSBF) late compared to other districts.

3.5 Study Population

The study population is formed of people or participants from whom a sample can be drawn (Singh, 2006). The target population of this study was all Core and Co – opted member of Council Health Management Team (CHMT), were involved in the study include, District Medical Officer (DMO), District Health Secretary (DHS), District Dental Officer (DDO), District Pharmacist (D-Pham), District Laboratory Technologist (DLT), District Nursing Officer (DNO), District Social Welfare Officer (DSWO), District Health Officer (DHO) and Co- opted members include, Medical Officer In charge of District Hospital (MOi/c), Hospital Health Secretary (HHS), Malaria Focal Person, Matron/Patron, Tuberculosis/Leprosy Coordinator (TB/Leprosy), TB/HIV Coordinator, DHIS Focal Person, CTC Coordinator, District Aids Control Coordinator (DACC), Reproductive Child Health Coordinator (DRCH-co) Radiologist In charge, Laboratory in charge, Wards In charges in District Hospital. The health facilities in charges and their assistants were also involved in this study.

3.6 Unit of Inquiry

The unit of inquiry of this study was the Council health management team in the District Council. The selected health facilities of Nachingwea District Council where the data were collected included Nachingwea District Hospital, Majimaji Hospital, Marambo health center, Naipanga dispensary, JKT dispensary, Old camp dispensary, Tunduru ya Leo dispensary, Mtepeche dispensary, Mwenge dispensary, Ruponda dispensary, Ulai dispensary, Ndomondo dispensary, Mtua dispensary, Kiparamtua dispensary, Kihuwe dispensary, Magereza dispensary, Mpiruka dispensary, Mkotokuyana dispensary, Chiola dispensary, and Ikungu dispensary. These Health facilities were obtained through simple random sampling procedure, where the total health facilities of 40, were assigned by numbers from which the (20) twenty health facilities were obtained. In those twenty (20) Health facilities, the researcher chose only in charges and their assistants who willingly participated in the study because they knew about the implementation of the funds rather than other health workers.

3.7 Unit of Analysis

The unit analysis of this study was Council Health Management Team members and in charges of health facilities and their assistants from the council health facilities in

Nachingwea District. Council Health Management Team members are the ones involved in budget planning and received the funds from the central government. The health facilities in charges and their assistants are recipients of the funds from the councils to deliver the health services within the community level through their health facilities. The study basically reflected respondents' information which intended to answer the hypothesis of the study and their information was analyzed and coded accordingly to suit them into Statistical Package for Social Science (SPSS) analysis.

3.8 Sample Size

In obtaining the sample of health facilities to be involved in the study within the communities, the study used descriptive research design to obtain the general descriptive of the respondents. The sample size contained twenty (20) Core and Co-opted members from the Council Health Management Team (CHMT), twenty (20) in charges and twenty (20) Assistants from the health facilities which give the total of sixty (60) respondents from the Nachingwea District Council.

Table 3.1 provides a brief description of the sample size distribution

Table 3.1 Sample Size Distribution

PARTICIPANTS FROM THE TWENTY (20) HEALTH FACILITIES AND CHMT MEMBERS							
		CHMT		**HF/Inch.**			
S/N	**Unit of inquire**	**F**	**M**	**F**	**M**	**T**	**Sample size**
1.	Council health management Team	7	13	0	0	20	**20**
2.	Health Facilities In charges	0	0	7	13	20	**20**
3	Assistants In charges/ Matron/Patron	0	0	16	4	20	**20**
	TOTAL	7	13	23	17	**60**	**60**

3.9 Sampling Techniques

The study involved both probability and non probability sampling techniques. In addition, Purposive and simple random techniques were used in this study. The purposive sampling technique was used to select the respondents because they were the ones had knowledge and experiences of the study, since; they received and implemented the activities supported by the Health Sector Basket Funds (HSBF) in the council. A simple random sampling technique was used to get the number of Health facilities involved in the study since it was difficult to include all health

facilities within the council. The simple random sampling technique was used to select twenty (20) health facilities among of forty (41) health facilities within the council which the study was conducted. While purposively sampling technique was also used to select twenty (20) Council health management team members and forty (40) health facilities in charges and their assistants.

3.10 Data Collection and Data Collection Techniques

The questionnaires were used in data collection for the purpose of this study. Both primary and secondary data were collected. The reason for using questionnaires was to obtain the information easily from the respondents since the study used quantitative research approach. The data collected was analyzed and coded accordingly and suited them into the Statistical Package for Social Science (SPSS).

3.10.1 Secondary data collection

The secondary data were mainly collected from documentary reviews like Quarterly financial and Technical reports, Comprehensive Council Health Planning (CCHP), Annual financial and Technical reports of 2015/2016, 2016/2017 and 2017/2018, District Health Information System (DHIS of 2016, 2017 and 2018) and CCHP guideline of 2011 which found within the District Council.

3.10.2 Primary data collection

The primary data are fresh data collected in the field through questionnaire survey and other methods such as interviews and Focus Group Discussion (FGD). The questionnaires were used in the study and distributed to all 60 respondents include, Council Health Management Team members (CHMT), Health facilities in charges and their assistants.

3.10.3 Questionnaire

The study employed the questionnaire survey using a questionnaire formulated of both open and closed ended questions to all respondents; it included the Council Health Management Team, Health facilities in charges and their Assistants. The need of using this was to get their opinion on the first, second and third research objectives as stated earlier. Questionnaires are set of questions normally designed to gather information from a respondent with the intention of getting an accurate proportion of responses which look similar or different. The questionnaire survey, data were judged basing on the number of respondents who shared the same feelings, understanding or

conviction about the subject in question. The questionnaire helps to test hypothesis or prove for the assumptions made and hence it needs to be free from bias, understandable and should motivate and create interest for respondents to read and answer the questions. The questionnaire enabled the researcher to get the responses from council health management team and health facilities in charges and their assistants on the health sector basket fund on improvement of health services provision in the health facilities at Nachingwea District Council. The questionnaire also generated a large amount of data and gave the respondents enough time to answer the questions. The questions were easily answered privately and easily quantified.

3.10.4 Documentary Review

The documentary review was based on processing the selected and summarizing written and pictorial documents containing information about the phenomena of the study. It also involves a data collection method derived from the already written materials or documents. The Secondary data collection involves subjecting documents related to the study obtained from the organization of Nachingwea District Council.

Those secondary data were obtained from Quarterly financial and Technical reports, Annual financial and Technical reports and Comprehensive Council Health Plan of 2015/2016, 2016/2017 and 2017/2018 were also reviewed to get the secondary data. The information obtained from these sources was used to check for the consistency of information generated through the use of questionnaire survey method and skills, since the documentaries proved the disbursement of Health Sector Basket Funds (HSBF) within the council whether received timely or late resembling to information also from respondents through questionnaire survey obtained the same information.

3.11 Data Analysis Procedure

The data collected was edited for accuracy, reliability, consistence and completeness. Therefore, the data were analyzed by using descriptive Statistics under the computer software Statistical Package for Social Science (SPSS) version 21.

3.12 Quantitative Analysis

The specific objectives number one, two and three yield quantitative data in examining the trend of health Sector Basket Fund (HSBF) disbursement of the fund for three consecutive financial years of 2015/2016, 2016/2017 and 2017/2018. Founded disbursement of fund in each quarter, planned versus actual received funds

and remaining funds for each quarter. Likewise, the objective number two found out the level of activities implemented within the council that were supported by the fund. Procurement of medical drugs, hospital supplies, equipments and accessories and training of health care providers on capacity building, disbursement of funds in each quarter. The objective number three based on finding out the challenges of implementers facing during implementing and the disbursement of funds. All these are the factors lead on improvement of health services provision were hypothesized was tested and quantitatively analyzed.

Descriptive statistics was used to analyze the quantitative data to get frequency, percentages and make a cross tabulation and then presented them in charts and tables. Data were edited for accuracy, readability, consistence, completeness and the coding was made for data entry, put into computer software and analysis on Statistical Package for Social Science (SPSS) version 21 programme.

3.13 Ethical Consideration

Ethical consideration is essential in many social science researches and can be thought of as the study of good conduct and grounds for making judgments about what is good or bad in research (Birch *et al*., 2002). The researcher adhered to the right procedures of conducting a study just from the preliminary stages of the study. A letter was sought from the Mzumbe University to allow the researcher to conduct the study. The permission was authorized at the District Council level to lowest level of wards and villages administrations. For the purpose of maintaining confidentiality and anonymity of interviewees, the names, details and official documents obtained from the participants were not disclosed without their own consent.

CHAPTER FOUR
RESEARCH FINDINGS PRESENTATION

4.1 Introduction

The presentation of findings of this study is organized under four main sections; section 4.2 provides social demographic characteristics of the Respondents which gives the general descriptive of the respondents, section 4.3 is about the trend of Health Sector Basket Fund disbursement for three financial years of 2015/16, 2016/17 and 2017/18 which represent the objective number one of the research study. Section 4.4, the activities supported by Health Sector Basket Fund (HSBF) implemented as planned representing the objective number two of the study and involved subsection of activities supported by Health Sector Basket Funds (HSBF) implemented as planned, the benefits of health workers through Health Sector Basket Funds (HSBF), the motivation and incentives of Health Sector Basket Funds (HSBF) to health care providers. Section 4.5 represents the perceived challenges of Health Sector Basket Fund (HSBF) implementation which is the objective number three, involved the challenges of implementers like inadequate transportation system and delayed in disbursement of funds from the central government to council level.

4.2 Demographic Characteristics of Respondents

The demographic characteristics of respondents presented based on one major group classified into two subgroups which included the respondents who were involved in administrative level with the health department and another group of in charges and assistants in charges with the health facilities. The first group mainly involved (20) Council Health Management Team (CHMT) members both Core and Co-opted members.

4.2.1 Demographic Characteristics of Respondents.

The social demographic characteristics of respondents are presented in Table 4.1. In this category, the researcher grouped the social demographic profile basing on sex, age, marital status, education level, professional status, position and work experience.

Table 4.1: Social – Demographic profile of respondents

Characteristics		Frequency	Percentage
Sex	Male	40	66.67%
	Female	20	33.33%
	Total	**60**	**100.00**
Age	Below 25 years	8	13.33%
	25 – 35 years	15	25%
	36 – 45 years	27	45%
	46 – 55 years	10	16.67%
	Total	**60**	**100.00**
Education level	Certificate /Diploma	38	63.33%
	Bachelor/Advanced D.	20	33.33%
	Masters Degree	2	3.33%
	Total	**60**	**100.00**
Work position	Management	20	33.33%
	Others	40	66.67%
	Total	**60**	**100.00**
Work Experience	Below 5 years	12	20%
	5 – 15 years	28	46.67%
	15 – 20 years	12	20%
	Above 20 years	8	13.33%
	Total	**60**	**100.00**
Professional Status	Medical Officer	2	3.33%
	Asst. Medical Officer.	8	13.33%
	Nursing/Asst. Nursing	26	43.33%
	Others	24	40.01%
	Total	**60**	**100.00**

Source: Field data, (2018).

The results in Table 4.1 show that, the male sex representation was found to be high in number of respondents by 66.67% compared to female respondents. About 33%, 25% and 45% of the respondents were aged between 25 and 35 years and 36 and 45 years old. This is implying that, the health facilities and council health management team was populated with energetic man power of human resources for health who could manage to work hardly with regards to education level, most Core members of the Council health management team (CHMT), seven (7) of them out of eight (8) were degree holders. This led to 87.5% of core council health management team members required qualified, according to the guideline of ministry of the health, required quality to be core members of council health management team only 12.5% had advanced diploma level of qualification. The co-opted council health management team members were the ones working in two style of job description, first as a technical skill to their professional cadre and second as a management position within the council level. Mostly they were found within the District Hospital working as technical personnel to improve the health services provision.

The dominant group of respondents was health facilities in charge and their assistants who were actively involved in working in dispensaries found in the rural areas. The findings show that, these were the most health workers who were providing health services to 80% percent of the Tanzania who are living in rural areas. According to the findings from the respondents, the dominant group had an experience of working in the sector in between 5 and 15 years which lead to 46.67%, followed by 15 and 20 years and below 5 years which a counted for 12% and other few respondents with working experience of above 20years. (Table4.1) the results show that, the respondents working experience was still at adult stage of professions who could actively work in the professional for more years for the development of the council.

4.2.2 Demographic characteristics of respondents.

In the case of field work area, both Council health management team members and Health facilities in charges and their assistants were involved in the study. The study involved twenty (20) council health management teams from managerial level of health department including eight core members and twelve (12) co-opted council health management team members. Further, the study went far to and manages to involve twenty (20) health facilities in charges and twenty (20) assistants from the health facilities.

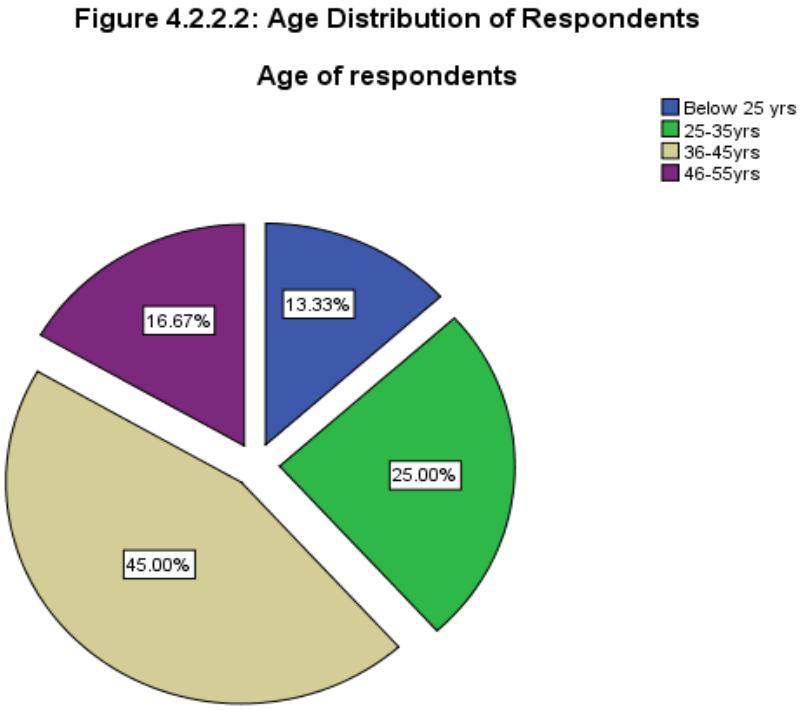
4.2.2.1 Sex representation of the respondents

In the case of the study interviewed of twenty Council health management team members, most of the managerial team within the health department in the council level composed of fifteen males and five females. Eight (8) Core members of council health management team were males, only and five females were co-opted members. In health facilities, most of males in charges owned the facilities compared to fewer females. Among of forty (40) in charges and their assistants, the researcher used simple random sampling to choose twenty (20) health facilities among of forty-one (41) found in the study area. All health facilities got equal chance to be selected to avoid biasness. The results show that, 62.5% of the respondents within the health facilities were males and 37.5% respondents were females. This shows that, males dominated the position of in charges and assistants in-charges in the health facilities compared to females.

4.2.2.2 Age distribution of the respondents

Respondents' age varied greatly between 25 and 35 years and 36 and 45 years. The council health management team members ranged between 36 and 45 years, while Health facilities in charges and their assistants ranged between 25 and 35 years. The twenty (20) council health management team (CHMT) members belonged to the similar adult age group of 36-45 years who could manage to work hard and under pressure due to their capability and energetic stage. The potentiality of their position and commitment to their responsibility, kept them to be addressed full to their performance within the management of the council level. The age range of 36-45 years had 45% higher coverage of man power, followed by 25-35 years, which covered 25%. The oldest man power was high about 16.7% compared to below 25 years which is 13.3%. This shows that, the rate of recruitment of youngest man power was low compared to the rate of oldest retired which was 16.7% (Fig.4.1).

Figure 4.1 The Pie chart below shows the age distribution of the respondents



4.3 The trend of Health Sector Basket Funds Disbursement for Three Financial year

The findings from this objective were covered and represented in five main areas. These areas included, funds budgeted in the financial year, and funds received in the financial year, expenditure of funds quarterly and remaining funds at the end of financial year. The findings show that, the council received the Health Sector Basket Fund according to the planned budgeted for three consecutive years. This trend of Health Sector Basket Fund disbursement of three financial years of 2015/2016, 2016/2017 and 2017/2018 is shown in the Table 4.3 below.

Table 4.2: The disbursement of Health Sector Basket funds for three financial years

Financial Year	Budgeted Funds	Received Funds
2015 / 2016	401,727,651.87/=	401,727,651.87/=
2016 / 2017	503,277,000.00/=	503,277,000.00/=
2017 /2018	428,394,800.00/=	428,394,800.00/=

Source: Field data (2018).

The council received Health Sector Basket Funds according to the budget and plan. In the financial year (FY) of 2015/2016, the council budget of Tsh.401, 727,651.87 for the implementation activities in the Health Sector Basket Funds (HSBF) source and was received as planned. Although the funds were disbursed late and quarterly on 17/10/2015, the amount received was Tsh.200,863,825.94 for 1st and 2nd quarter and on 16/03/2016, the amount received was Tsh.200,863,825.94 for 3rd and 4th quarter but all funds were received as budgeted.

The next financial year of 2016/2017, the council budgeted Tsh.503, 277,000.00 and received the same amount as budgeted. On 14/11/2016 Health sector Basket funds received by the council was Tsh.251,638,500.00 for 1st and 2nd quarter. Another quarter of 3rd and 4th, the council received Tsh.251,638,500.00 on 12/04/2017 which covered the full actual amount of funds budgeted. Another financial year (FY) of 2017/2018, the council planned and budgeted Tsh.428, 394,800.00. On 15/12/2017 the received amount of the Health sector basket funds was divided quarterly as usual. In the 1st and 2nd quarterly the funds received was Tsh.214, 197,400.00 which led to the aggregate of what was budgeted by the council. These findings show that, the amount of funds the council budgeted and planned is the same as the amount received and implemented accordingly. So, what had planned and budgeted is what had received and implemented accordingly as the table shown.

4.3.1 Expenditure and implementation status of the activities

In such situation of funds received to the Council level from the Central government, the council managed to perform implementation according to the funds received. For stance in the financial year of 2015/2016, the Health Sector Basket Fund received was Tsh.401,727,651.87 and the council managed to utilize Tsh.259,609,653.62 which is equal to 64.62% of the implementation of the all financial year. Unspent funds remained was Tsh.142,117,998.25 which is equal to 35.37% were carried over to the next financial year.

In the following financial year of 2016/2017, the council received Health Sector Basket Funds of Tsh.503,277,000.00; the amount was added with unspent funds of Tsh.142,117,998.25 as it was brought forward from the financial year of 2015/2016. The overall reading of funds in the same financial year was Tsh.645,394,998.25. The expenditure of this financial year increased and implementation status exceeded due to brought forward activities carried from the previously financial year of 2015/2016. The expenditure became Tsh.623,626,603.57 which was equal to 123.91% of expenditure compared to the actual expenditure of 100% percentage. According to the funds budget by the council and received in the financial year of 2016/2017, without considering the brought forward amount, the council managed to spend Tsh.445,601,455.80 which is equal to 88.54% from implementation status. The remained unspent balance of Tsh21,768,394.68 which is equal to 4.33% was carried forward and to be implemented in the next financial year of 2017/2018.

The last assessment of financial year of 2017/2018, the council budgeted Tsh.428, 394,800.00 and received the same amount as planned, but the council managed to spend Tsh.424,628,904.68 which is equal to 91.12% of implementation status. The brought forward amount remained from the financial year of 2016/2017, Tsh.21, 768,394.68 was transferred to financial year 2017/2018 for its implementation and the overall amount became Tsh.450,163,194.68. The implementation status for the overall financial year became 99.12% which is equal to Tsh.424; 628,904.68.The unspent balanced was Tsh.25,534,290.00 which was equal to 5.67%. This implementation status and expenditure has been illustrated in Table 4.4.

Table 4.3 Expenditure and implementation status of the activities for three FY of 2015/2016, 2016/2017 and 2017/2018

Financial Year	Expenditure	Remained/Amount	Implementation Activities	Implementation Status
2015/2016	259,609,653.62/=	142,117,998.25	89	64.62%
2016/2017	623,626,603.57/=	21,768,394.68	76	123.91%
2017/2018	424,628,904.68/=	25,534,290.00	54	99.12%

Source: Field data (2018).

These findings explain the reality that, for the three consecutive financial years of 2015/2016, 2016/2017 and 2017/2018, the Health Sector Basket Funds received by the council was with regard to the amount budgeted. In the financial year of 2016/2017, the Health Sector Basket Fund released from the central government was higher than compared to the previously year of 2015/2016 and the following year of 2017/2018. The implementation status of 2016/2017 was above hundreds percentage (100%) due to forwarded amount remained unspent from the previously year of 2015/2016 to be carried for over for other activities. In 2017/2018, the disbursement of funds from the central government to Council level reduced the amount compared to the previously year of 2016/2017. The activities seemed to be fewer in the financial year of 2017/2018, against the implementation status because the government through the Ministry of Health, Community development, Gender, Elderly and Children (MoHCDGEC) enacted the policy of direct health facilities financing (DHFF) and practicing the same financial year.

The policy based on the health activities to be performed by the Health facilities level. This practicing system leads to improvement of the implementation of the activities and upgraded the implementation status to 99.12% and reduced the conjunction of unimplemented activities compared to the previously financial year of 2015/2016 and 2016/2017.

4.3.2 Disbursement of Health Sector Basket Funds in each quarter

The results show that, although the Health Sector Basket Fund received was based on what was budgeted by the council, still there was a delay in disbursement of the funds from the central government to the council level authority. On the financial year of 2015/2016, the council failed to utilize efficiently the Health Sector Basket Funds received. On top of that, the council afforded to spend only 64.62% of the

implementation status. This means unspent amount was high compared to the precedent financial year of 2016/2017 and 2017/2018. The findings also indicated the reality that, after the government had enacted the policy of Direct Health facilities financing (DHFF), the implementation statuses were improved and successful, since the health facilities were cascaded to implement the activities. The health services provision was improved efficiently after the implementation and practicing of Direct Health facilities financing (DHFF). The council health management teams were based on other managerial activities like quarterly reports writing and submission to the Regional secretariat level. The health Sector Basket Funds were disbursed accordingly to the conditioned met by the council level. The funds are only disbursed to the council if and only if one of the serious requirements had correctly met and was the correct and timely submission of the council technical and financial reports of the preceded quarter. No funds are to be disbursed unless there was prerequisite required.

Table 4.4 Date Funds received implementation activities and remained activities.

FY	Received	Date received	Implementation	Actual	Rem.	%Implementation
2015/2016	200,863,825.94	17/10/2015	89	138	49	64.62%
	200,863,825.94	16/03/2016				
2016/2017	251,638,500.00	14/11/2016	76	79	3	95.67%
	251,638,500.00	12/04/2017				
2017/2018	214,197,400.00	15/12/2017	54	56	2	99.12%
	214,197,400.00	22/02/2018				

Source: Field data (2018).

There is a delaying in disbursement of funds from the central government as ongoing process proceeding years after years. On financial year (FY) of 2015/2016, the council received half amount of budgeted in the last first quarter on 17/10/2015 of the financial year. The council received another final amount on 16/03/2016 after three month ended of financial year of 30th June 2016. The received amount was a half of the budget of Tsh**.**200, 863,825.94 failed to be utilized on the given specific time. The amount was carried over on the next financial year of 2016/2017. This shows that, delayed in disbursement of fund led to unimplemented of other planned activities on a specific period of time were the conjunction of implemented activities increased and results of insufficient utilization of funds on the specific budgeted financial year. In additions findings represented the situation that, the trend of Health Sector Basket

Funds received by the council does not follow the time schedule of the implementation activities. The funds were received late and the activities were not implemented at all as per planned quarter. For instance, in the financial year of 2016/2017, the Health Sector Basket Funds was also disbursed late to the council. In order to carry over the activities and bring forward the amount from the last financial year of 2015/2016, the council was overloaded with extra activities and funds remained on the last financial year. The council managed to implement 64.62% out. The practicing system was proceeding in the financial year of 2016/2017 where the amount brought forward exceeded.

Although the implementation status was over 100% percentage, but still other activities were not implemented at all and the brought forward funds were transferred to next financial year of 2017/2018. In this financial year, the government practiced the system of District Health facilities financing (DHFF) which other activities were implemented at the facilities level. This system increased the implementation status of the council and the performance was growing up due to decentralized of implementation authorities to health facilities called cascade system. The practicing of this policy was very successfully and all funds delayed to be spend in the council level were fully utilized and, other challenges like interruption of ad hock activities faced by the councils led to delayed in implementing activities were resolved.

4.4 The Activities Supported by Health Sector Basket Funds Implemented as Planned.

This second objective was based on the implementation status of the council activities supported by Health Sector Basket Funds. For the three financial years as shown that, all activities supported by Health Sector Basket Fund were implemented as planned although were not fully implemented on the planned quarterly. The financial year of 2015/2016, the council planned 138 activities of Health Sector Basket Funds (HSBF), but it managed to implement 89 activities only which are equal to 64.62% implementation status. On the financial year of 2016/2017, the council planned 79 activities of Health Sector Basket Funds (HSBF) and 76 activities were implemented which is equal to 95.67% of implementation status. The last financial year of 2017/2018, the council planned 56 activities of Health Sector Basket Funds and managed to implement 54 activities which are equal to 99.12% of implementation

status. This trend shows that, although there are carried over activities, the activities supported by Health Sector Basket Funds (HSBF) are implemented as planned.

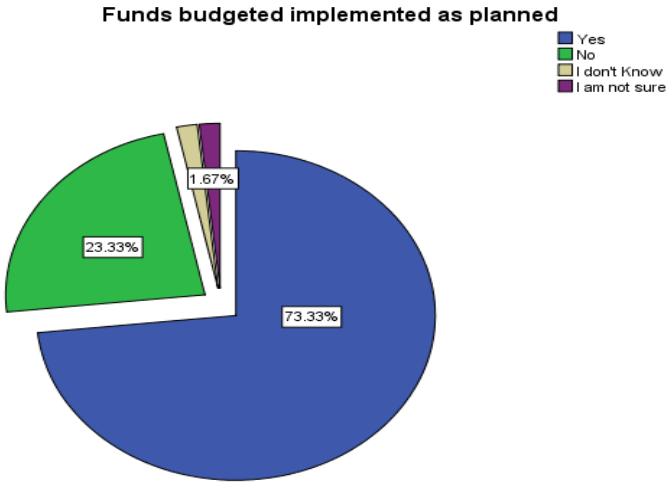
Table 4.5 The HSBF budgeted and implemented as planned

	Frequency	Percent
Yes	44	73.3
No	14	23.3
I don't Know	1	1.7
I am not sure	1	1.7
Total	60	100.0

Source: Field data (2018).

The respondents from the council also indicated the situation of Health Sector Basket Fund (HSBF) implementation activities as planned. Forty-four (44) respondents out of sixty (60) respondents which is equal to 73.3% accepted that, the activities supported by Health Sector Basket Funds (HSBF) were implemented as planned only fourteen (14) respondents, which is, equal to 23.3% out of sixty (60) did not accept the activities supported by Health Sector Basket Fund (HSBF) as planned. The rest two respondents, one answered that did not know (1.7%) and another not sure (1.7%). The explanation above can be illustrated in Figure 4.4.0 below;

Figure 4.2: The Health Sector basket Funds budgeted and implemented as planned



4.4.1 Training of Health workers for developing their Skills performance

The findings explained the activities supported by Health Sector Basket Funds implemented and how the Health care providers benefited with the funds. Fifty one (51) respondents equal to 85% out of sixty (60) respondents accepted that, the health care providers attended trainings in order to develop their skills performance in their working station. Only four (4), equal to 6.7% of respondents out of sixty (60) did not accept that the health care providers attended trainings for developing their skills within their working station and Five (5) which was equal to 8.3% were not sure (Table 4.4).

Table 4.6 Health care providers attending training skills development and performance improvement

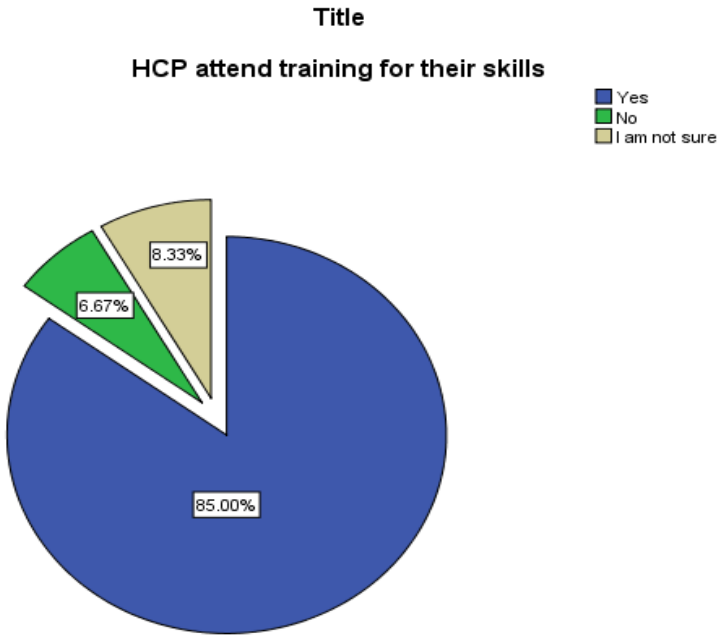
	Frequency	Percent
Yes	51	85.0
No	4	6.7
I am not sure	5	8.3
Total	60	100.0

Source: Field data (2018).

It shows that 51 respondents accepted that the Health care providers attended training for the improvement of their skills performance which accounted for 85%, while 8.3%

were not sure and 4 respondents equal to 6.6% said 'No'. The dominant groups of respondents who accepted showed that, the Health Care Providers attended training (Figure 4.4.1).

Figure 4.3: The pie chart of Health care providers attending training for skills development and performance



4.4.2 The benefits of Health workers through Health Sector Basket Funds

The results show that, on top of the funds supported in improvement of health services provision but also health workers benefits through the funds by attending seminars, short trainings and sensitization. Thirty (31) which is equal to 51.7% of the respondents accepted that the health care providers received high benefits through Health Sector Basket Fund (HSBF), while twenty (26) respondents, which is equal to 43.3% agreed that, there was medium benefits of health care providers (HCP) through Health Sector Basket Funds, two (2) respondents which is equal to 3.3% said there is low benefits of health care providers through Health sector basket funds while one (1) said no benefits of health care providers in Health sector basket funds. The results show that, there is high benefits health workers received through Health Sector Basket Funds. This explanation can be illustrated in the table figure below;

Table 4.7: The benefits of Health Workers through Health Sector Basket Funds

		Frequency	Percent
	High benefits	31	51.7
	Medium benefits	26	43.3
	Low benefits	2	3.3
	None of above	1	1.7
	Total	60	100.0

Source: Field data (2018).

4.4.3The motivation and incentives of HSBF to Health care providers

Most of the health facilities face the scarcity of human resources for health, scarcity of the health facilities within the council level Hospitals, Health centers and Dispensaries. Health care providers are needed to be in call for other extra hours than normal working hours stipulated. Due to the scarcity of human resources for health, the situation becomes more difficult to handle. Most health care providers are getting paid of call allowances, extra duties and Night allowance to motivate as incentives to them due to difficult works they performed.

Table 4.8: The motivation and incentives of HSBF to Health care providers

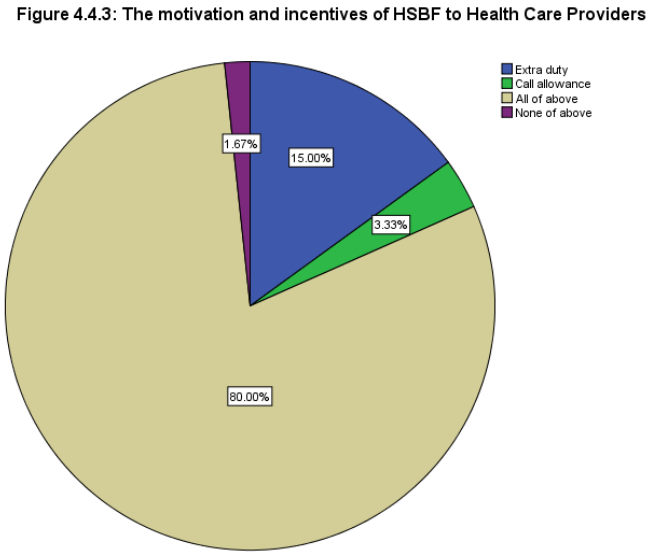
	Frequency	Percent
Extra duty	9	15.0
Call allowance	2	3.3
All of above	48	80.0
None of above	1	1.7
Total	60	100.0

Source: Field data (2018)

The funds further provide motivation and incentives to the Health workers who are working in the health facilities within the Council. Forty eight (48) respondents equal to 80% agreed that, the funds provided high motivation and incentives to health workers (Table 4.5). Nine (9) of 15% of respondents agreed that, only extra duty was provided to health care providers, while two (2) respondents 3.3% said that, only call allowance was provided by the funds and one (1) respondents 1.7% said that, there

was no motivation or incentive provided through the fund. The results show that, there are motivation and incentives provided to Health care providers through Health Sector Basket Funds.

Figure 4.4: Motivation and incentives of HSBF to Health Care Providers



About 80% of respondents accepted that, the motivation and incentives were provided to health care providers in performing their works. This is done due to shortage of the human resources for health. In order to encourage them, to fulfill the situation, the motivation like extra duty, call allowance and night allowance were provided in order to harmonize the situation.

4.5 The Challenges in Implementation of Health Sector Basket Funds

The council faced some challenges in the implementation of health department activities supported by Health Sector Basket Fund (HSBF). One was the compulsory ad hock activity instructed by the Central government with political influence to be implemented on time to the Council. Sometimes the climatic condition interfere the implementation of some activities, poor infrastructure network brought difficulties to reach the Health facilities to support health services. The Table 4.5 shows the challenges in the implementation of Health Sector Basket Funds.

	Frequency	Percent
Delay in disbursement of funds	16	26.7
Transport problem	1	1.7
all above true	43	71.7
Total	60	100.0

Source: Field data (2018).

Table 4.5, shows the respondents' interpretation of challenges in the implementation of the Health Sector Basket Fund (HSBF). About 2.7% of respondents show that, there was a delay of disbursement of funds from the central government which led to inadequate implementation of Health Sector Basket Funds (HSBF) activities in the council, while 1.7% of the respondents claimed the problem of transportation and 71.7% of the respondents agreed that the council faced the challenges of delay in disbursement of funds and inadequate transportation.

The results show that, 71.6% of the respondents agreed on the challenges that the council faced in implementation of Health Sector Basket Fund as they were delayed in disbursement of funds and transport problem. Most of cars which are found within the council especially in the Nachingwea District Council, are obsolate which needs more maintanance and replacement to get another cars to afford to reach and work in the hard to reach area. The council faced budget constraints in the own source funds and can not manage to buy other brand new cars to be utilized in the council activities. The Council Health Management Team failed to implement supportive supervison efficiently due to inadequately transportation and funds which led to unsuccesful implementation status of the activities at the ended quartely. The council through health department try their level best for preparation and submision of quartely reports timely to the regional secretariate before 15th after the end of quarterly time in order to meet the conditio of Health Sector Basket Fund (HSBF) disbursement with submission of all quartely reports timely but still the delay of funds disbursement from the central government remains.

4.5.1The challenges of implementers

There are many challenges facing the implementers during the implementation of the activities of Health Sector Basket Funds (HSBF). The council faced the ad hock activities which affected the implementers to perform their duties on time due to scarcity of human resource for health. The council health management team, especially co-opted members who are supposed to perform two sides on their work, duty post and substantive post. In substantive post, the deal with professional technical skills to provide health services to the clients within the District hospitals.

Another duty post, they have to go for out reaches in the Health facilities to support their health care providers in the technical issues of treatment and other skills needed which are not provided and lack to be provided in the health facilities due to absence of professional skills workers.

The co-opted members lack subordinate to delegate their position within the working station, this happened due to shortage of professional workers within the working area. Most of the remained staffs are not competent enough to perform their duties given by their supervisors.

4.5.2 The challenges in disbursement of funds

The Health Sector Basket Funds are disbursed if and only when the conditions are met by the councils. One of the serious requirements is the correct and timely submission of the council technical and financial reports of the proceeded quarter. There is no disbursement of funds to be made unless the prerequisite accepted by the councils. The Nachingwea District Council is the one of the council, which follows and meets the conditions given by the donors of Health Sector Basket Funds, but still the delay in disbursement of funds exists. In all the three financial years of 2015/2016, 2016/2017 and 2017/2018, the Nachingwea District Council managed to conduct submission of quarterly reports to regional level timely before the date of 15th after finishing the quarterly. Table 4.5.2 shows the challenges in disbursement of the funds.

	Frequency	Percent
Yes	13	21.7
No	47	78.3
Total	60	100.0

Source: Field data (2018).

The results show that, only thirteen (13) respondents which are equal to 21.7% out of sixty (60) respondents accept that, the Health sector basket funds were disbursed on time in the councils, while forty seven (47) respondents equal to 78.3% out of sixty (60) respondents did not accept that, the Health Sector Basket Funds were not disbursed on time in the councils. The delay in disbursement of funds to the council affected the performance of the Council. The activities were reserved without being implemented which at the end the council was subjected to unspent balances which at the end of financial year brought to audit query.

CHAPTER FIVE
DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter discusses the findings of the study obtained in the chapter four. The discussion of the findings is based on the research objectives. The chapter comprises of four sections. The first section discussed the social demographic characteristics of respondents. The second section discussed the trend of Health Sector Basket Funds disbursement for three financial years 2015/2016, 2016/2017 and 2017/2018. The third section discussed the activities supported by health Sector Basket Funds implemented as planned and the last section discussed the perceived challenges of Health Sector Basket Funds implementation.

5.2 The Demographic Characteristics of Respondents

The main categories used in the study for social demographic characteristics of respondents were, sex, age, education level, position held in health department and health facilities and work experience. However, the study respondents were council health management team members both core and co-opted members and health facilities in charges and their assistants. In case of sex presentation, the study found that, the representation was fair though male sex dominated as compared to females to about 67% where as female sex group made 33.33%. The two different groups comprised the matured workforce, youth generation which implied that, their energetic nature to perform and exercise their professionalism of improving health services within the councils. The council health management team comprised of eight (8) core members and twelve (12) co opted members. The explanation of this implies that, council comprises maturity group of work force who are energetic and can think deeply to work and perform the duties hardly and timely due to their experience and education level.

The education level of most respondents from the council health management teams and health facilities in-charges had basically degree and diploma holders. The council faced scarcity of skilled human resources for health in their health facilities level, which may result to inadequate health services provision. The Ministry of Health guideline directs clearly to stipulate that every health facility especially at dispensary

levels, should have at least a clinical officer who should manage clinical duties in health services provision to clients and not otherwise. This guideline was not met by the councils which reflect most district councils in the country. The age group is ranging between 46 and 55 years comprised of old respondents approaching the retirement age. This group represents for16.67% as compared to the young generation which was 13.33%. The findings show that, after the 5 and 14 years, the council will lose about 17% of human resources for health, and the observation and experience show that, the recruited to cover the gap may not be adequately done. The major action of replacement should be taken to overcome the situation.

The literature shows that; the government now is trying to reduce the recruitment in the councils which is a good exercise but may also lead to the decrease of human resources for health in the government sectors. The council should make sure that, they announce this as among the majors' challenges which can affect the work performance of the council especially in the health facilities and led to inadequate provision of quality health services to the people within the communities. The working experience of the Council health management team members and in charges with their assistants in the health facilities were good enough to notify the competence and ability of the health department management for their delivered work performance.

5.3 The trend of Health Sector Basket Fund (HSBF) disbursement in three financial years 2015/16, 2016/2017 and 2017/2018.

According to the results, the three consecutive financial years of 2015/16, 2017/18 and 2017/18, the council received Health Sector Basket Fund (HSBF) as planned and budgeted. In the financial year 2015/16, the council received Tsh.401, 727,651.87, in 2016/17, the council received Tsh.503,277,000.00 and last 2017/18 the council received Tsh.428, 394,800.00.

The trends of disbursement imply that there is a different amount of disbursement in each financial year, where in some financial years, the fund increases and in the other shows a decrease. It was also observed that, the government did not disburse all the funds budgeted on the financial year at once; they just disbursed once for two quarters. This led to difficulties in expenditure and management for the

implementation of the activities, because the council through health department. On top of implementing the activities according to the schedule, they started to priotize which activities should start first to be implemented. Those activities which involved the procurement of the drugs, medical supplies and medical equipments, are given the first priority to be implemented first, due to little funds received in first phase by the councils. This is because, in the mind of most people in the communities, once when one talks about health services provision, they think of availability of medical drugs, equipments, accessories and supplies in the health facilities.

The council prefers to implement all the procurement activities first, with all the funds received in order to avoid bad perception of the communities and political implications which may rise due to the absence of medical drugs and supplies within the health facilities. By doing so, other planned activities which were supposed to be implemented on the first and second quarters were postponed to wait for the next phase of disbursement. The trend negatively affects the management and implementation of activities in the council, the poor timing of fund release to the council lead to the failure in utilizing the funds received. This happened in the trends of all the three financial years of assessment 2015/2016, 2016/2017 and 2017/2018.

5.4 The Activities Supported by Health Sector Basket Funds (HSBF) Implemented as Planned.

Through the results of the study, it had been noted that, all the activities supported by health Sector Basket Funds (HSBF) were implemented as planned for the three consecutive financial years of 2015/2016, 2016/2017 and 2017/2018. All the activities, the council planned and budgeted the activities of Health Sector Basket Fund (HSBF) well as follows, in 2015/2016 the activities planned were 138, in 2016/2017 the activities planned were 79 and in 2017/2018 the activities planned were 56. The implementations of activities in 2015/2016 were 89, in 2016/2017, the activities implemented were 76 and in 2017/2018, the activities implemented were 54. This implied that, although the implementation was not successful to 100% as planned, but all the activities were implemented and the remained activities were carried over in the next financial year and implemented as budgeted. The council should make sure that, at the end of the financial year, all the activities remained without implemented should be put in the Medium Term of Expenditure (MTEF) before receiving the funds of another financial year. Without demonstrating that, the

council should be in audit query for not identifying the carried over activities of the past financial year which also implied there is brought forward funds.

The council finished to implement the previously activities of the last financial year, the recent activities implemented was 95.67% and the amount spent was Tsh.481, 508,605.32 and unspent balanced was Tsh.21,768,394.68. The remained amount was carried forward to another financial year of 2017/18 and the total amount read Tsh.446,397,299.36. In this financial year, the government through Ministry of Health, Community Development, Gender, Elderly and Children started to practice the new policy system of District Health facilities financing (DHFF), and the system involved the health facilities to implement the activities and council health management team (CHMT) only based on supervising them.

The system practiced by the council was cascade system of decentralization by devolutionary (D by D). The practice system of District health facilities financing (DHFF) initiated the speed of implementation status of the Health Sector Basket Funds (HSBF) activities within the council and brought to rise up the implementation status to be 99.12%. It has been proved that, since the policy of decentralization by devolution started to be practiced in the council, the implementation status rose up to 99.12%. This shows that, the system of District health facilities financing (DHFF) is successful to increase expenditure of the funds and implementation of activities in the council and reduces the audit query of unspent balanced at the end of the financial year.

About 73.3% of the respondents agreed that, all the activities supported by the Health Sector Basket Fund (HSBF) were implemented as planned; except23.3% of the respondents who did not agree that, the activities supported by the Health Sector Basket Fund (HSBF) were implemented as planned. The group of respondents, who said ‘Yes’, they dominated, the results that, all activities supported by the HSBF implemented as planned. Some of activities implemented, involved training of health care providers for developing their skills performance. About 85% of the respondents said that, Health care providers attended training in order to develop the skills performance. The council conducts trainings to their health workers in order to develop their skills, to build their capacity and increase new knowledge in their working station. For the workers who are working in rural areas, training increase

knowledge and ability of working confidently in order to overcome the difficult situations which may sometimes occur in their working stations.

Health care providers (HCP) benefit and receive motivation and incentives through Heath Sector Basket Funds (HSBF). About 52% of the respondents agreed that, health care providers received high benefits and 43.3% said that, medium benefits. This implies that, Health Sector Basket Funds (HSBF) provides benefits to the health workers in the council. The motivation and incentives like extra duty, call allowance and night allowance are provided through Health Sector Basket Funds (HSBF). This has been shown in the respondents' answers that, 80% of the respondents agreed that, health care providers received motivation and incentives through Health Sector Basket Fund (HSBF). Motivation and incentives to health care providers reduces stress to workers and increases morally and encouragement for working hard and under pressure since they knew that, they are recently recognized by the top management levels.

5.5 The Challenges in Implementation of Health Sector Basket Fund

According to the Table 4.5 in chapter four (4), all data that are contained in the table under objective three (3), show the delayed in disbursement of funds and transport system has dominated large amount about 72% of the respondents are the council health management team (CHMT) members and health facilities in charges. They mentioned the challenges implemented Health Sector Basket Fund (HSBF). Nachingwea District Council is among of the other districts in Tanzania facing the problem of transport facilities. Most of the cars in the health department of Nachingwea District Council need high maintenance in order to be reliable to reach various places. Due to absence of reliable transport in the council, some activities such as outreach activities, supportive supervision and distribution of drugs, gas cylinders and accessories may hinder their implementation.

When assessing the implementation status of Health Sector Basket Fund in the Nachingwea District Council, during the study for three consecutive financial years, of 2015/2016, 2016/2017 and 2017/2018, the numbers of activities were not implemented at all due to several reasons. Among of those reasons include, delay of disbursement of funds, interruption of ad hock activities from the central government

and inadequate team working among of the council health management. For the comparison purposes, the study displayed the three past financial year of Health Sector Basket Funds (HSBF) unspent balance as presented in the Table 5.5.

Table 5.1 Unspent balances from 2015/2016 to 2017/2018.

S/No	Financial Year	Unspent Balances as per 31th June	Percentage for Unspent Balance (%)
01	2015/2016	142,117,998.25	35.37%
02	2016/2017	21,768,394.68	4.33%
03	2017/2018	25,534,290.00	5.96%
		189,420,682.93	**45.66%**

Source: Field data (2018)

The total amount of Tsh.189, 420,682.93 in the last three financial years implies that, Nachingwea district council had activities that, worth this amount, which were not implemented in time schedule and affected the health services which the money was to be spent. The study revealed this trend of unspent money was proceeding with an exception of 2016/2017 where it decreased for 4.33% if you compared to the financial year of 2015/2016 and 2017/2018.

This implies that, assessing the three financial year implementation status, the results are informing that, the good news in the financial year of 2017/2018, was the introduction of practicing District Health facilities financing (DHFF) in the council. The practicing policy system results to raise implementation status to 99.12% compared to other financial years of 2015/2016 and 2016/2017 which was 64.62% in 2015/2016 and 95.67% in 2016/2017 according to fund received without considering the carried over activities from the previously financial year of 2015/2016 which was 28.24%.

CHAPTER SIX
SUMMARY, CONCLUSION, RECOMMENDATION AND POLICY IMPLICATION

6.1 Introduction

The chapter presents the summary, conclusion, recommendation and Policy implication of the study.

6.2 Summary

The study explored the implementation of Health Sector Basket Funds (HSBF) on improvement of health services provision in Nachingwea District Council. It specifically, examined the implementation of Health Sector Basket Funds (HSBF) to ascertain whether it was implemented as indicated in the Comprehensive Council Health Planning (CCHP). In order to attained this, the study specifically, examined the trend of Health Sector Basket Fund (HSBF) disbursement for three financial year of 2015/2016,2016/2017 and 2017/2018, determined the activities supported by Health Sector basket Funds (HSBF) implementation in the council, and the challenges of Health Sector Basket Funds (HSBF) implementation within the council.

The study was concluded that, at Nachingwea District Council the quantitative research method approach with Cross-sectional research design, where the researcher met the respondents at once was used. In the sampling, the study used the simple random sampling and purposively sampling techniques. The simple random sampling was employed to select twenty (20) health facilities among of eighty (80) included in the study. In addition, purposely sampling technique was used in selecting the total of sixty (60) respondents, whereby twenty (20) among them were Council health management team members and forty (40) were health facilities in- charges and their assistants, who were aware with the Health Sector Basket Fund (HSBF) since they were mainly involved in the preparation of planning and budget of the health department within the council. The sample size was made by sixty (60) respondents. The content analysis and descriptive statistical analysis were applied to the analyze data. The findings of the study are presented in chapter four and discussed in chapter five. The presentation of the key findings was done following the series of the specific objectives.

6.2.1 The trend of Health Sector Basket Fund (HSBF) disbursement for three financial years of 2015/2016, 2016/2017 and 2017/2018.

The study found that, there is delaying in disbursement of funds from the central government to the council levels. The findings show that, for the three consecutive financial years, the Council proceeded to received late the Health Sector Basket Funds (HSBF) from the central government started from the 2015/2016 financial year up to 2017/2018. The amount received also, was based on quarterly session. The disbursement was done for two quarters which was half of budgeted amount of all financial year. The next amount was disbursed in 3rd and 4th quarters, but at the end all Funds were received as budgeted.

Majority of the respondents (78.3%) said that, the council was not receiving the Health Sector Basket Fund (HSBF) timely, while 21.7% accepted that, the council received Health Sector Basket Fund (HSBF) on time. The group of respondents who disagreed the Health Sector Basket Fund (HSBF) was not received by the council timely. The findings were compressed on the documentary reviewed found in the council which shows that, for the three consecutive years, the Health Sector Basket Fund (HSBF) were received late timely. In 2015/2016, the funds were received on 17/10/2015 and 16/03/2016 for the 1st up to 4th quarter, in 2016/2017 the funds were received on 14/11/2016 and 12/04/2017 for the first to fourth quarters. The last financial year of 2017/2018, the council received the funds on 15/12/2017 and 22/02/2018; this confirms that, the Health Sector Basket Fund (HSBF) is being received at late time in the council.

6.2.2 The activities supported by Health Sector Basket Funds (HSBF) implemented as planned.

The study found that there was a moderate implementation of activities supported by Health Sector Basket Fund (HSBF) as planned. The findings show that, in 2015/2016 financial year the council managed to implement 89 activities out of 138 activities planned in the budget which was equal to 64.62% of implementation status. Another financial year of 2016/2017, the council managed to implement 76 activities out of 79 activities planned in the budget which was equal to 95.67% without including the activities planned from the previous financial year of 2015/2016. However, the implementation was 124% including activities carried over and led to exceed 100% of implementation status.

In another financial year of 2017/2018, the 73.3% of the respondents dominated the group which said that, the activities supported by Health Sector Basket Fund (HSBF) were implemented as planned; while 23.3% percent disagreed that, the activities supported by the Health Sector Basket Fund (HSBF) were not implemented as planned. The council managed to implement 54 activities out of 56 activities planned in the budget which was equal to 99.12% percent of the implementation status. This shows that, the activities supported by Health Sector Basket Funds (HSBF) are implemented as planned in the budget.

6.2.3 The challenges in implementation of Health Sector Basket Funds

The Council implementers faced the challenges in implementing activities supported by Health Sector Basket Funds (HSBF). Among of the challenges include first, the compulsory ad hock activities of political issue instructed by the central government level to be implemented on time to the council. This led to other activities to stop first until the instructed activity finished. The climatic condition and poor infrastructure network which cause the difficulties in reaching the health facilities for supporting health services.

Other challenge is transport system faced the council. Most of cars in the council were not reliable to be used. They need to be maintained, serviced and worn out to the good condition. About 72% of the respondents agreed that, delay in disbursement of funds and transport problem were major challenges in implementation of Health Sector Basket Fund (HSBF). The delay in disbursement of funds and transport problem dominated a large group and resulted to the actual reality of the situation. Most of subordinate were not capable and competence to work on the position given to act on behalf of their immediately supervisors. This was due to their poor skills and knowledge they had on it and led to existing the shortage of human resources for health.

6.3 Conclusion

Based on the presentation of findings and discussions in chapter four and five, with regard to the implementation of Health Sector Basket Fund (HSBF) on improvement of health services provision in Nachingwea district council, is true on the fact that, implementation of Health Sector Basket Fund (HSBF) within the council, improved the health services provision.

Although there are several challenges, the council faced in implementation of the funds like, delaying in disbursement of funds from the central government, interruption of ad hock activities, unavailability of reliable transport system and inadequate skills human resources for health within the council, however all planned activities supported by Health Sector Basket Fund (HSBF) are implemented as planned on the Comprehensive Council Health Planning (CCHP).

The delaying in disbursement of funds as been shown in the three consecutive financial year of 2015/2016, 2016/2017 and 2017/2018, when the funds were received untimely leads to unsuccessful implementation of activities as planned schedule. Due to remained unspent funds for example in 2015/2016, where unspent amount was Tsh.142, 117,998.25 which was equal to 35.38% of un implemented activities, means this amount was not utilized to spend for the improvement of health services provision to the health services in the rural areas in the financial year of 2015/2016. Most of people within the communities did not receive health services due to inadequate implementation of the fund and this has happened due to delaying of the disbursement of the funds from the central government.

6.4 Recommendations

Form the results of the study; the researcher gives the following recommendations for effective implementation of Health Sector Basket Funds (HSBF)

6.4.1 The major result on this study shows that, The Health Sector Basket Fund (HSBF) improve the health services provision in Nachingwea District Council. But, there were delaying in disbursement of fund in the council for the three consecutive financial years of 2015/2016, 2016/2017 and 2017/2018. The government should release the funds on time for effective utilization and implementation of activities in the budget. The delay affects the procurement of drugs, equipments, accessories and medical supplies.

6.4.2 The government and politicians in general should think of ad hock activities assigned to the councils as the pressure may somewhat comprise the quality of services and implementation of activities.

6.4.3 The councils through General Funds or own source during preparation of budget, should make sure they allocate the budget for procuring one new car

in every financial year which will help to facilitate the collection of taxes within each financial year.

6.4.4 The scarcity of human resource skills has been shown as a major challenge in Tanzania, especially in the southern part region of Lindi and Mtwara and Nachingwea District Councils in particular. The government and stakeholders in development, and development partners in general should address this challenge in various forums such as during the Primary Health care (PHC). The District Executive Director (DED) of all councils and their District Commissioner (DC), the Regional Administrative Secretariat (RAS) as they are potential personnel in the District Councils. Should work together to make sure the fund works timely and as it requiring.

6.5 Policy implementation

Since the disbursement of Health Sector Basket Fund (HSBF) from the central government involved a complex condition to be met by the councils in order to receive the funds, councils have to submit the quarterly reports early before the date of 15th after the end of quarterly session. Most of the council including Nachingwea District Council meets the conditions, but there was a delay of the funds in reaching the councils timely.

The policy is only acted to the council without considering the central government which is actually responsible disbursing the funds to the District Council. The central government should make sure that, the funds are released on time, by doing that, and it may reduce the complication in the implementation of activities within the councils. The government should accommodate the parliament budget session earlier so, when a new financial year starts, all the formalities for the new expenditures can take place timely.

6.6 Suggestion areas for further studies

The study suggests that there may be a study to examine the contribution of Health Sector Basket Funds (HSBF) on improvement of health services provision in the Local Government Authorities. The current study has only covered the implementation of the Health Sector Basket Funds (HSBF) and the challenges in the implementation and disbursement. The suggested study should also find out whether

the delay in disbursement of funds is caused by late submission of the implementation reports from the councils or there are other factors.

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APPENDICIES

Appendix 2: QUESTIONNAIRE FOR THE SURVEY TO EXAMINE HEALTH SECTOR BASKET FUND ON IMPROVEMENT OF HEALTH SERVICE PROVISION WITHIN A DISTRICT COUNCIL.

Questionnaire No / Code [ ]

GENERAL INFORMATION

Date: ……. Name of Enumerator/Interviewer…….

Name of Health Facilities……..Region: ……District……

Ward: …….. Village……Position/Title of Enumerator……..

1.0 SECTION 1: BACKGROUND INFORMATION

1. What is your sex?
   - (i) Male ( )
   - (ii) Female ( )
2. How old are you?
   - (i) Below 25 years ( )
   - (ii) 25-35 years ( )
   - (iii) 36-45 years ( )
   - (iv) 46 -55Years ( )
   - (v) Above 55years ( )
3. What is your marital status?
   - (i) Married ( )
   - (ii) Single ( )
   - (iii) Divorced ( )
   - (iv) Widow or widower ( )
4. What is your education level?
   - i) Certificate /Diploma in education ( )
   - ii) Bachelor/Advanced of education ( )
   - iii) Master degree/Post graduate Diploma ( )
   - iv) Doctor of Philosophy. PhD ( )

5. What is your professional status

i) Medical Officer ( )

ii) Assistant Medical Officer ( )

iii) Nursing/Assistant Nursing Officer ( )

iv) Others ( )

6. What is your position in the health facility/District Council?

……

7. How long have you been working in these Health facilities?

i) Below 5 years ( )

ii) 5-15 years ( )

iii) 15-20 years ( )

iv) Above 20 years ( )

2.0 SECTION II: IMPLEMENTATION OF THE HEALTH SECTOR BASKET FUND

8. Does the council receive Health sector basket fund on time?

i) Yes ( ) ii) No ( )

9. Does the council receive all Health sector basket funds as budgeted and planned?

i) Yes ( ) ii) No ( )

10. Do all funds budgeted implemented as planned?

i) Yes ( ) ii) No ( )

ii) I don't Know ( ) iv) I am Not Sure ( )

11. Do, health care providers attend trainings for developing their skills in order to increase performance in their working station?

i) Yes ( ) ii) No ( )

iii) I don't know ( ) iv) I am not sure ( )

12. Are you getting information when the funds received and the remaining after the end of the quarter from the Council Management?

i) Yes ( ) ii) No ( )

13. Is there any meeting conducted when the Health sector Basket fund received from the Central Government?

i) Yes ( ) ii) No ( )

14. Who do you think is supposed to inform you when the Health sector Basket Fund received by the District Council level from the Central government?

i) District Medical Officer (DMO) ( )
ii) District Executive Director (DED) ( )
iii) District Treasury (DT) ( )
iv) You don't Know ( )
v) None of the above ( )

15. In your Comprehensive Council Health Planning (CCHP) which fund is used for the preparation of Health department Budget?
    i) Health sector Basket Fund ( )
    ii) Other charges Fund ( )
    iii) General /own source Fund ( )
    iv) Cost Sharing Fund ( )
    v) None of the above ( )
16. How many planned activities supported by Health sector basket funds have been implemented in the Comprehensive Council Health Plan (CCHP) of the financial year i)2015/2016 ……ii)2016/2017…….iii) 2017/2018 ……..
17. Do all members of Council Health Management Team (CHMT), health Facilities in charges aware with the Comprehensive Council Health Planning (CCHP)?
    i) Yes ( ) (ii) No ( ) (iii) They are not sure ( ) (iv) Not all ( )
18. What is the important of the fund in implementing the activities of health services within the Council level?
    i) Very important ( )
    ii) Moderate important ( )
    iii) Somehow important ( )
    iv) Not important ( )
    v) None of the above ( )
19. To what extent do the Health workers benefits through Health Sector Basket Fund?
    i) High benefit ( )
    ii) Medium benefit ( )
    iii) Low benefit ( )

iv) None of the above ( )

20. What motivation and incentives do the Health workers receive through the Fund?
    i) Extra Duty ( )
    ii) Call Allowance ( )
    iii) Night Allowance ( )
    iv) All of the Above ( )
    v) None of the above ( )
21. What are the challenges do the council facing on receiving Health Sector Basket Fund?
    i) Delay in disbursement of funds from central government ( )
    ii) Incompletely disbursement of funds from the central government ( )
    iii) All of the above is true ( )
    iv) None of the above is true ( )
22. What are the majors challenges do the implementers facing in implementing activities supported by Health sector basket fund?
    i) …….
    ii) ……
    iii) ……
23. What do you think will happen if the fund is not provided in the District Council?
    i) Most of the health activities will be collapsed ( )
    ii) Some of the health activities will be collapsed ( )
    iii) All the activities will be collapsed ( )
    iv) Nothing will be collapsed ( )

THANK YOU VERY MUCH FOR YOUR GOOD COOPERATION