
**YOUTH ACTION VOLUNTEERS**

# Council Comprehensive Health Plans Review for Kinondoni, Ilala, and Temeke Municipal Councils and Kibaha District Council

**31st May 2008**

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| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AMMP | Adult Morbidity and Mortality Program |
| ARI | Acute Respiratory Infection |
| ARV | Anti-retroviral therapy |
| CBHC | Community Based Health Care |
| CBPM | Community Based Pregnancy Monitoring |
| CCHP | Council Comprehensive Health Plan |
| CHMT | Council Health Management Team |
| DC | District Council |
| DOTS | Direct Observed Therapy |
| EPI | Expanded Program for Immunization |
| HMIS | Health Management Information System |
| HIV | Human Immunodeficiency Virus |
| IEC | Information, Education and Communication |
| IMCI | Integrated Management of Childhood Illnesses |
| MC | Municipal Council |
| MDGs | Millennium Development Goals |
| MKUKUTA | *Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania* |
| MTEF | Medium Term Expenditure Framework |
| NGO | Non-Governmental Organization |
| NMS | National Minimum Standards |
| NSGRP | National Strategy for Growth and Reduction of Poverty |
| OC | Other Charges |
| PE | Personal Emoluments |
| PER | Public Expenditure Review |
| PRSP | Poverty Reduction Strategy Paper |
| PTB | Pulmonary Tuberculosis |
| RHMT | Regional Heath Management Team |
| RS | Regional Secretariat |
| SMI | Safe Medication Industry |
| STI | Sexually Transmitted Infection |
| TB | Tuberculoses |
| TShs | Tanzanian Shillings |
| URT | United Republic of Tanzania |
| UTI | Urinary Tract Infection |
| YAV | Youth Action Volunteer |

# 1.0 INTRODUCTION[1]

Since 1990s onwards Tanzania re-examined its approach towards the Health Sector and initiated the development of Health sector Reforms which aimed at addressing the structural problems with the Health system itself. The health sector reforms have been conducted simultaneously with other reforms such as Local Government Reforms and poverty reduction programs. The Poverty Reduction Strategy Paper [PRSP] (2000) underscored the importance of adequate provision of social services in building and strengthening human capabilities.[2] Thus, in PRSP I, primary education, water and sanitation, and health were identified as priority sectors for poverty reduction. Others included agriculture, rural roads, and judiciary[3]. During the implementation of PRSP I, the government focused its attention to these sectors through the annual budgets and the Public Expenditure Reviews (PER) and Medium Term Expenditure Framework (MTEF) process.

Thereafter, the Government approved the PRS II known as the National Strategy for Growth and Reduction of Poverty (NSGRP), popularly known by its Kiswahili acronym as MKUKUTA *(Mkakati wa Kukuza Uchumi na Kuondoa Umaskini Tanzania*) in early 2005. The NSGRP keeps in focus the aspirations of Tanzania's Development Vision (Vision 2025) for high and shared growth, high quality livelihood, peace, stability and unity, good governance, high quality education and international competitiveness. It is committed to the Millennium Development Goals (MDGs), as internationally agreed targets for reducing poverty, hunger, diseases, illiteracy, environmental degradation and discrimination against women by 2015.[4] These are addressed in the three clusters spelt out in the MKUKUTA:

*Cluster 1: Growth and Income Poverty Reduction*
*Cluster 2: Improvement of Quality of Life and Social Wellbeing*
*Cluster 3: Governance and Accountability*

Health issues are addressed extensively in Cluster II although the three MKUKUTA Clusters are synergetic in the sense that achievement of health outcomes described in Cluster II is dependent on achievement of outcomes in Clusters I and II. For instance, sufficient

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1 Responsibility for the opinions presented in this review rests with the author alone (Dr Flora Lucas Kessy of Ifakara Health Research and Development Centre [IHRDC]) and should not be attributed to Youth Action Volunteers.

2 United Republic of Tanzania [URT] (2000), "Poverty Reduction Strategy Paper," Dar es Salaam: Vice President's Office.

3 HIV and AIDS and Gender were also identified under cross cutting issues.

4 URT (2005), "National Strategy for Growth and Reduction of Poverty (NSGRP)." Dar es Salaam: Vice President's Office.

economic growth will result to a stable economy that is able to fund its functionaries. Further, proper management of resources through good governance will result to effective and efficient spending of resources.

Tanzania has also been implementing the Local Government Reform which is a major institutional reform program aimed at increasing accountability and efficient use of human and financial resources at the local authority. The Local Government Reforms Policy has resulted to decentralization of financial management to Local Authorities, which entails financial discretionary powers to the local councils. In this respect, local councils are to levy local taxes, and the government is to provide block grants for recurrent expenditure to Local Authorities. Financial decentralization allows local councils to pass their own budget reflecting their own priorities, as well as mandatory expenditure required for the attainment of national standards. Conditional block grants are also to be provided from the Center. The Sector Ministries are to provide input concerning minimum standards services on which determination of block grants are to be based. The Ministry responsible for local government is to coordinate central-local relations, and in particular all initiatives from sectoral ministries on matters relating to local government.

As the process of Decentralization by Devolution (D by D) unfolds, the need to initiate planning process at the local government level becomes imperative. This has been so in the preparation of District Comprehensive Plans that consolidate activities to be done by different sectors in order to achieve certain stipulated sector goals and objectives. In the districts that have advanced in the reforms and decentralization process, activities of Non-Governmental Organizations (NGOs) operating in the district have been included in these plans. This is imperative in ensuring effective coordination of activities and thus avoiding duplication.

In that line of thinking, the Council Comprehensive Health Plans (CCHPs) have been initiated as planning and budgeting tools for health interventions at the local council level. Since 1999, a number of guidelines were developed to guide Councils in preparing CCHPs to ensure cost effective utilization of funds. These guidelines aimed at bridging the performance gap among the Councils in the management of district health services and to enhance the decentralization process. The 2007 guideline presents a third review which accommodated the Council Health Management Teams (CHMTs) and Regional Secretariat (RS)/Regional Health Management Teams (RHMTs) observations in particular with rigidities arsing from restrictions on the use of basket fund[5].

[5] See United Republic of Tanzania (2007), *Comprehensive Council Heath Planning Guidelines*, February, Ministry of Health and Social Welfare and Prime Minister's Office, Regional Administration and Local Government.

Substantive chapters in a typical CCHP include chapter one which is an introduction that provides the purpose of the comprehensive plan, reference documents used, the profile of the district in terms of specific socio-economic indicators, the planning techniques and logistics, followed by chapter two on situation analysis whereby the level of services provides, for example, inpatient and outpatient care, mortality ratios, health initiatives in the Council are also reported in this chapter. Further, this chapter presents achievements, challenges, opportunities, and problems for proper implementation of Council health interventions. The review of resources available including human, materials, financial resources and physical health infrastructure status is presented in chapter three. The Plan further describes the priority problems facing the Council in chapter four, followed by objectives, targets and planned prioritized interventions in chapter 5. Finally, detailed plan of operations for the whole year and per cost centre is presented in chapter six, targets, monitoring and performance indicators in chapter seven and assumptions and risks in chapter eight.

In line with the production of CCHPs is the production of detailed Financial and Technical Reports or sometimes known as the Annual Implementation Report for Council Comprehensive Health Plans. These reports are produced quarterly and annually and among other things they show the budgetary allocation to different interventions and by cost centre and achievement of the district specified health indicators and challenges in reaching the stipulated milestones.

# 2.0 THE PURPOSE AND OBJECTIVES OF THE REVIEW

The CCHPs and the Annual Technical and Financial Reports act as accountability tools that can be used to effect positive changes in the budget and health interventions. Accountability is an obligation by politicians and government officials to explain their performance and justify their decisions. Youth Action Volunteers (YAV) being one of the stakeholders having mandate and interest in the performance of the health sector reviewed the performance of 2005/06, 2006/07, and 2007/08 CCHPs for Kinondoni, Ilala, and Temeke Municipal Councils and Kibaha District Council with aim of providing information on the management of public resources in the district health departments. The emphasis of YAV policy is placed on equitable distribution of quality of health services for each respective district.

The general objective of the review is to establish issues related to citizen participation, accountability and transparency in health sector planning and budget management for effective performance of the district health department. The specific objectives of the review are to:

1. Assess respective district planning and resource allocation to ascertain all resources (monetary and non-monetary) available for delivery of health services for three financial years.

2. Assess the effectiveness and efficiency of expenditure management by districts, by comparing respective budget allocations with expenditure reports for three years.

3. Assess management performance of each district health department and assess delivery of quality health services and infrastructure by each district.

4. Assess district specific public integrity processes and capacity to respond to cases of misuse and/or abuse of public resources.

5. Assess available Auditor and Controller General's findings and implementation of oversight committee resolutions.

6. Assess whether preceding year experiences have incrementally informed and improved subsequent years planning, implementation and reporting.

7. Draw general as well as specific district observations and conclusions.

# 3.0 APPROACHES AND METHODS

## 3.1 The Scope and Approach

This study was a purely desk review of the documents listed in Table 3.1.

**Table 3.1: The List of Reviewed Documents**

| Sn | Name of the Council | Reviewed Documents |
|---|---|---|
| 1. | Ilala MC | (a) CCHP 2005/06<br>(b) CCHP 2006/07<br>(c) CCHP 2007/08<br>(d) Annual Financial and Technical Report for the Period July 2005 to June 2006<br>(e) Annual Implementation Reports for Council Comprehensive Health Plans 2006/07<br>(f) Report of the Controller and Auditor General on the Financial Statement of Ilala Municipal Council for the financial year ended 30th June 2006. |
| 2. | Temeke MC | (a) CCHP 2005/06<br>(b) CCHP 2006/07<br>(c) CCHP 2007/08<br>(d) Annual Technical and Financial Report 2006/07<br>(e) Report of the Controller and Auditor General on the Financial Statement of Temeke Municipal Council for the financial year ended 30th June 2006. |
| 3. | Kinondoni MC | (a) CCHP 2006/07<br>(b) CCHP 2007/08 (Volume II)<br>(c) Annual Implementation Report for Council Comprehensive Health Plan 2006/07<br>(d) Report of the Controller and Auditor General on the Financial Statement of Kinondoni Municipal Council for the financial year ended 30th June 2006. |
| 4. | Kibaha DC | (a) CCHP 2005/06<br>(b) CCHP 2006/07<br>(c) CCHP 2007/08 (revised version with basket ceiling of 0.75 per capita).<br>(d) Annual Progress Report for Period of July 2006 to June 2007.<br>(e) Report of the Controller and Auditor General on the Financial Statement of Kibaha District Council for the financial year ended 30th June 2006. |

## 3.2 Themes for Review

1. **Planning and Resource Allocation**: Here we assess the respective district planning and resource allocation (both monetary and in-kind) that are available for delivery of health services. Issues addressed include;
    (i) Trends on resource allocation (both in nominal and real term)
    (ii) Percent contribution of each type of financing source

(iii) Trends in resources used for actual interventions and those used for personal emoluments and other charges

(iv) Trends in allocation of Basket Fund

2. **Effectiveness and Efficiency of Budget Execution**: By comparing budget allocations with expenditures for each year we are able to establish the effectiveness and efficiency of budget execution. Issues addressed include:

   (i) Comparison of the budget allocations with the actual funds collected as reported in the CCHPs

   (ii) Allocations per cost centres and priority areas

   (iii) Comparison of the budget allocations in the CCHP with actual expenditures as reported in the financial reports

   (iv) Examination of the fourth quarter expenditure to establish whether there was lumping.

   (v) Comparison of the financial figures reported in the CCHP and the annual technical and financial reports to establish consistency.

3. **Performance Management**: Under this theme we assess how the Councils perform in implementation of their plans (CCHPs). Issues reviewed include:

   (i) The status of implementation of interventions identified in the CCHP (these include infrastructural related and non-infrastructure).

   (ii) Assessment of the performance of the District health indicators as presented in the CCHP and as monitored by the Health Management Information System (HMIS).

4. **Public Integrity Processes**: Here we assessed district specific public integrity processes the major ones being;

   (i) Existence of mechanisms to prevent the misuse/abuse of public resources, and the capacity to respond to cases of misuse and/or abuse of public resources

   (ii) Freely availability of the Auditor and Controller General's Reports and timely response on the queries raised in these reports[6].

5. **Informed and Improved Planning Process**: Here the review team assessed whether preceding year experiences have incrementally informed and improved subsequent years planning, implementation and reporting.

[6] A thorough analysis of the Report from the Controller and Auditor is done in another review.

# 4.0 ILALA MUNICIPAL COUNCIL

## 4.1 Introduction

The Ilala Municipality is one of the three Municipalities in Dar es Salaam region with an estimated population of 720,392 people as projected from 2002 census with an annual increase rate of 4.6% in 2007. Table 4.1 shows the vital statistics for the district. The mode of health service delivery in Ilala Municipal Council is based on curative, preventive and promotive health care and rehabilitative services provided by either private or government owned health facilities. These include hospitals, health centres and dispensaries.

In 2004, the top five diseases in the Municipal were found to be malaria, pneumonia, Urinary Tract Infection (UTI), diarrhoea diseases and Acute Respiratory Infections (ARI). In 2005, malaria, pneumonia, and diarrhoea infections remained on the list of the top five diseases plus tuberculosis and skin infection whereas in 2006 the top five diseases in the Municipal were found to be malaria, acute respiratory infection, pneumonia, urinary tract infection and tuberculosis.

Both the 2006/07 and 2007/08 CCHPs were developed basing on the laid down priorities addressed in the 2006/07 to 2009/2010 Council Strategic Plan with focus on;

(i) Reducing under five and maternal mortality rate;
(ii) Combating the spread of HIV and AIDS, malaria and tuberculosis.
(iii) Community involvement through Health Board and Committees;
(iv) Improvement of environmental health sanitation, Information, Education and Communication (IEC) and Community Based Health Care (CBHC); and
(v) Availability of human, financial and materials resources for better delivery of health services.

In the analysis presented in this chapter and subsequent chapters, the following terms have been used:

(i) **Cost Sharing Funds**: These are funds collected at the health facility from the users of the health services.

(ii) **Basket Funds**: These are funds contributed by donors to the health sector basket. The allocation of these funds to the district is based on a specific formula which is based on the population of the district (70%), poverty rate (10%), burden of disease (10%) and geographical size (10%). Further, there are specific ceilings for allocation of these funds to district departments.

(iii) **Block Grant**: This is the contribution from the central government to cover Personal Emoluments (PE) which includes salaries and other allowances and Other Charges (OC) which covers health interventions in the district.

(iv) **Receipt in Kind**: This include resources that are not necessarily received in monetary terms, mostly drugs.

(v) **Other Sources of funds**: These are other sources of funds that are not channelled through the government or the basket. These include funds from others donor who do not channel funds through the basket or the central government machinery.

(vi) **Municipal Council Funds**: This is contribution from the Municipal/District Council coffer to the district heath sector budget.

## 4.2 Analysis of CCHPs and Technical and Financial Reports[7]

### 4.2.1 Planning and Resource Allocation

Analysis of CCHPs was done to gauge the available financial and non-financial resources for delivery of health services. Table 4.1 shows the trends in budgetary allocations from different sources for health service delivery in the Ilala Municipality. There is notable increase in the nominal budget allocation in the three years except for two items; funds from the Municipal Director which increased sharply in 2006/07 but declined in 2007/08 and the Other Sources. In nominal terms, the total budget increased by 65.6% from 2005/06 to 2006/07 but only a small increase in observed in from 2006/07 to 2007/08 (12.6%). From 2006/07 there was improvement in reporting on funds from block grant. The OC and PE have been reported separately which means one can know exactly what money from block grant was used for actual interventions and which was used for personal emoluments. While the PE more than doubled from 2006/07 to 2007/08, the OC has remained constant. There is notable increase in the cost sharing funds. The increase was small (3% from 2005/06 to 2006/07) but increased substantially from 2006/07 to 2007/08 (37.5%).

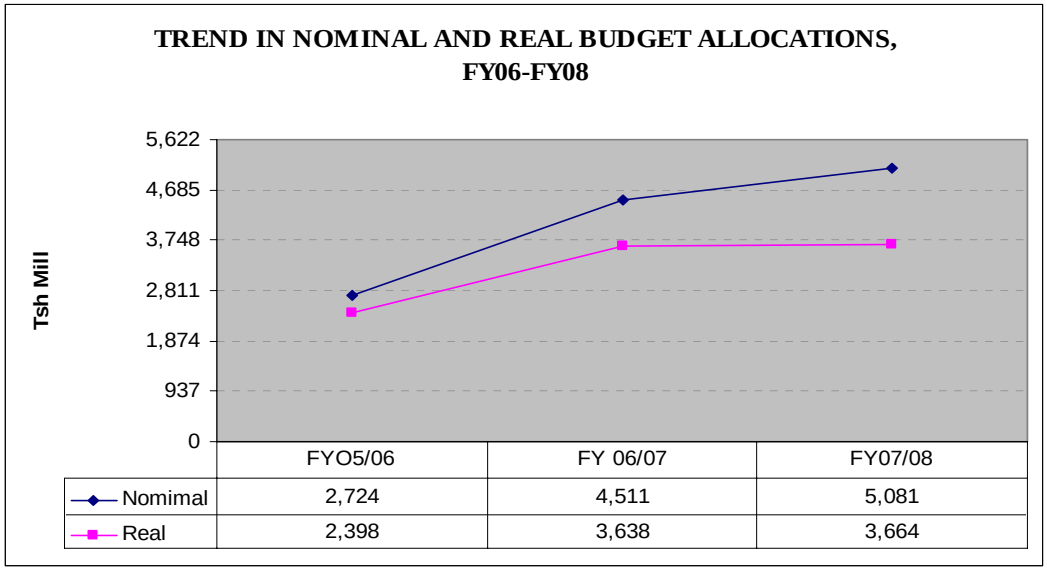
[7] Note that Technical and Financial Reports and Annual Implementation Reports for Council Comprehensive Health Plans contain the same information; only that some councils prefer to use one or the other.

**Table 4.1: Funds from Various Sources (TShs)**

| Sn. | Source of Funds | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|
| 1. | Cost sharing funds | 295,453,079 | 304,727,850 | 419,000,000 |
| 2. | Basket fund | 316,925,300 | 365,000,000 | 415,000,000 |
| 3. | Municipal Director | 284,972,571 | 993,594,978 | 800,931,066 |
| 4. | Block grant for OC and PE | 1,445,401,900 | - | - |
| | *Block grant for PE/Salary* | - | *1,755,035,100* | *2,649,011,730* |
| | *Block grant for OC* | - | *208,000,000* | *208,000,000* |
| 5. | Receipt in kind (drugs) | 343,363,000 | 486,680,000 | 797,256,735 |
| 6. | Other Source | 172,721,500 | 398,369,387 | 272,246,700 |
| | **Grand Total** | **2,724,038,617** | **4,511,407,315** | **5,081,446,231** |

Figure 4.1 compares the nominal increase versus real increase in allocations for the past three years. As the figure portrays, in real terms, there was a notable increase in the budget from 2005/06 to 2006/07 but the budget has remained almost constant in the 2006/07 to 2007/08 period due to high Consumer Price Index.

**Figure 4.1: Trend in Nominal and Real Budget Allocation**




Source: CCHP 2005/06; 2006/07; 2007/08

Note: The Consumer Price Indices (CPI) used: 2005/06=113.6; 2006/07=124; 2007/8=138.7.

Table 4.2 shows the percent contribution of each type of funding source. The basket grant contributed a bigger share for all the three years. Although nominally the cost sharing funds has increased, it has declined as the percent of the total budgetary allocations for 2006/07 and

2007/08. The same is observed for the basket funds. There is substantial increase of the allocations from the Municipal Director (more than doubled from 2005/06 to 2006/07 but a decline is observed in 2007/08 budget.

**Table 4.2: Percent Contribution of Each Type of Funding Source**

| Source of Funds | 2005/06 | % of total | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|---|---|
| Cost sharing | 295,453,079 | 11 | 304,727,850 | 7 | 419,000,000 | 8 |
| Basket fund | 316,925,300 | 12 | 365,000,000 | 8 | 415,000,000 | 8 |
| Municipal Director | 284,972,571 | 10 | 993,594,978 | 22 | 800,931,066 | 16 |
| Block grant | 1,445,401,900 | 53 | 1,963,035,100 | 44 | 2,857,011,730 | 56 |
| Receipt in kind (drugs) | 343,363,000 | 13 | 486,680,000 | 11 | 797,256,735 | 16 |
| Other Source | 172,721,500 | 6 | 398,369,387 | 9 | 272,246,700 | 5 |
| **Grand Total** | **2,724,038,617** | **100** | **4,511,407,315** | **100** | **5,081,446,231** | **100** |

The following are issues are gauged from the analysis done in this sub-section:

- *Separating PE from OC is commended; one can know exactly what money from block grant was used for actual interventions and what share goes to personal emoluments.*
- *Increase in the cost sharing fund over time (in nominal terms) is a positive trend which could be taken to mean that health services users are starting to accept that health financing is the responsibility of both the state and citizens. However, the cost sharing funds as percentage of the total Council budget declined in 2007/08 financial year compared to 2005/06 financial year.*
- *The central government through the block grant (for OC and PE) remains the main source of funds for the Municipal health interventions.*
- *There is a notable increase in the PE from 2006/07 (51% increase). This is however not commensurate with the trend in OC allocation; this has remained constant in the two financial years. The implication is that no improvement from the central government for the OC which affects implementation of priority interventions. This leaves funding for interventions on the hands of development partners through basket funding and other sources and Municipal own sources.*
- *Errors in reporting; funds from sources as reported in the executive summary do not match with what is reported in the text (for example see Table 1 on page 3 and Table*

*16 on page 15-16 (2005/06 CCHP); and Table 1 on page 3 and Table 19 on page 22 (2007/08 CCHP).*

- *Other sources of fund have not been defined. A footnote explaining what these other sources of funds are will be illuminating.*

- *The balance brought down as unspent funds in the previous years are not indicated in the CCHPs. For consistency, this has to be included in the CCHPs when determining funds available for the planning year; the unspent funds should be considered as a source of fund in the next year's budget.*

### 4.2.2 Effectiveness and Efficiency of Expenditure Management

Comparisons were made between the budgetary allocations as reported in the CCHPs and the actual received funds (Table 4.3).

**Table 4.3: Budgetary Allocations versus Actual funds Received**

| Source of funds | Allocated for the planning period (2005/06)* | Received/ collected (2005/06)** | Allocated for the planning period (2006/07)** | Received/ collected (2006/07)*** |
|---|---|---|---|---|
| Block grant (PE) | 1,132,655,424 | 1,132,655,424 | 1,755,035,100 | 1,755,035,100 |
| Block grant (OC) | 169,447,743 | 169,447,743 | 208,000,000 | 208,000,000 |
| Council own resources (Recurrent) | 178,061,536 | 178,061,536 | 426,804,978 | 426,804,978 |
| Council own resources (Development) | - | - | 566,790,000 | 566,790,000 |
| Basket grants | 316,925,300 | 316,925,300 | ***365,000,000*** | ***374,764,000*** |
| Cost sharing (hospital, health centre, dispensary) | 192,287,495 | 192,287,495 | 304,727,850 | 304,727,850 |
| Receipt in kind (drugs) | 279,595,271 | 279,595,071 | 486,680,000 | 486,680,000 |
| Other donors | 43,422,987 | 43,422,987 | 398,369,387 | 398,369,387 |
| **Grand Total** | **1,783,085,257** | **1,783,085,257** | **4,511,407,315** | **4,521,171,315** |

*Reported in the 2005/06 CCHP pp 15-16.
**Reported in the 2006/07 CCHP pp18-19.
***Reported in the 2007/08 CCHP p 22.

- *One weakness noted is that for both years, the allocated resources in the previous years have been recorded as received funds in the next year implying that the budget is the same as actual (only basket grants allocations differ in 2006/07). This is intriguing in particular for the funds that are not predictable for instance cost sharing funds.*

- *Again, in the Annual Implementation Report (2006/07) it is reported that in the period 2006/2007 a total of TShs 4,804,254,665 was received from various sources. This information is inconsistent with the figure reported in the 2007/08 CCHP (Table 3).*
- *The collected figure as reported in the CCHP 2007/08 for 2006/07 is TShs 4,521,171,315 which is close to the money spent (not collected) as reported in the Annual Implementation Plan (TShs 4,508,708,696).*

Examination of allocations per cost centres show that the municipal hospital takes a big chunk of the municipal health funds (close to 50% of the total in 2005/06) [Table 4.4]. The next big spender is municipal dispensary (close to 20% of the total budget). The three CCHPs show the allocations to allowances and fuel to be within the allocated ceiling.

**Table 4.4: Budget Allocations per Cost Centre**

| Cost Centre | 2005/06 | % of total | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|---|---|
| MMOH | 355,665,849 | 15 | 640,842,070 | 16 | 559,324,140 | 11 |
| Municipal Hospital | 1,135,153,385 | 48 | 1,669,983,386 | 42 | 2,263,281,026 | 45 |
| Municipal Health Centre | 393,351,234 | 17 | 660,943,404 | 17 | 974,960,138 | 19 |
| Municipal dispensary | 426,756,012 | 18 | 846,785,905 | 21 | 1,073,610,727 | 21 |
| Community | 31,826,370 | 1 | 126,172,750 | 3 | 210,270,200 | 4 |
| **Total** | **2,342,752,850** | 100 | **3,944,727,515** | 100 | **5,081,446,231** | 100 |

Table 4.5 shows trends in allocation of Basket Fund per cost centre. The Table shows that almost the same proportion of the funds have been allocated to the cost centres for the three years. However, the CCHP does not provide the ceiling allowed per cost centre.

- *In order to enhance transparency, we propose that CCHPs should show the ceiling allowed per cost centre and provide explanation whenever the allocations deviate form the allowed ceiling.*
- *Allocations per priority areas are not indicated in the Ilala Municipal CCHPs. It is imperative to indicate what funds have been allocated to priority areas of Municipal for effective health outcomes.*

**Table 4.5: Trends in Allocation of Basket Fund per Cost Centre**

| Cost Centre | 2005/06 | % of total | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|---|---|
| MMOH | 63,385,060 | 20 | 71,110,200 | 19 | 82,100,000 | 20 |
| Municipal Hospital | 110,923,855 | 35 | 128,891,850 | 35 | 144,425,000 | 35 |
| Municipal Health Centre | 63,385,060 | 20 | 75,110,200 | 21 | 83,000,000 | 20 |
| Municipal Dispensary | 63,385,060 | 20 | 71,110,200 | 19 | 83,000,000 | 20 |
| Community | 15,846,265 | 5 | 18,777,550 | 5 | 22,375,000 | 5 |
| **Total** | **316,925,300** | **100** | **365,000,000** | **100** | **415,000,000** | **100** |

Note: MMOH=Municipal Medical Office of Health

Table 4.6 presents the sources of funds as reported in the CCHPs but comparing with the figures reported in the annual implemental report. As Table 4.6 reveals, there is inconsistency between what is reported in the CCHP as actual money collected when compared to figures reported in the annual implementation report. The inconsistency is particularly high on the funds from the Municipal Director and receipt in kind where the difference is more than 100%.

- *In drafting the annual implementation report, it is imperative to explain the difference especially when the difference is as large as observe on the funds from the Municipal Director and receipt in kind.*

**Table 4.6: Sources of Funds: CCHPs versus Annual Implemental Plan Figures**

| Sn. | Source of Funds | Fourth Quarter (2005/06) | Received/ collected (2006/07)* | 2006/07 (Annual Report Figures) |
|---|---|---|---|---|
| 1. | Cost sharing funds | 105,164,692 | 304,727,850 | 332,692,961 |
| 2. | Basket fund | | 374,764,000 | 374,764,000 |
| 3. | Municipal Director/Council Funding | 70,000,000 | **993,594,978** | **455,124,978** |
| 4. | Block grant for PE/Salary | 548,028,131 | 1,755,035,100 | 1,755,035,000 |
| 5. | Block grant for OC | 114,305,000 | 208,000,000 | 208,000,000 |
| 6. | Receipt in kind (dtugs) | 103,527,938 | **486,680,000** | **1,041,178,321** |
| | Joint Rehabilitation Fund | 110,250,000 | - | 110,250,000 |
| 7. | Other Source | 188,091,301 | 398,369,387 | 392,346,792 |
| | **Grand Total** | **1,426,749,063** | **4,521,171,315** | **4,669,392,053** |

*Reported in the 2007/08 CCHP p 22.

There is obvious dumping of funds in the last quarter of 2005/06 financial year. It is reported in the CCHP that delay in funds is one of the reasons that hinder smooth implementation of the Municipal activities. For instance, the third and fourth quarter funds from Block Grant were received late (29 June 2007).

- *Dumping of funds in the last quarter affects the implementation of the planned activities, and as a corollary failure to achieve the intended yearly outcomes.*

### 4.2.3 Performance Management

Assessment of the annual implementation reports show that almost all activities were fully implemented except few activities. The few activities that were not implemented were attributed to delay of funds. For instance, as pointed above, third and fourth quarter funds from Block Grant (OC) were received late (29 June 2007). This has affected the implementation of the planned activities. The cash book balance at the end of the period (30.06.2007) was TShs 295,545,968; this means that this sum was not available on time for implementation of the planned activities.

Table 17 of the 2005/06 CCHP describes the Council health problems, the long term objectives, the output to be achieved and areas of interventions to achieve the outputs. We draw the output detailed in this Table and examine whether they were achieved (Table 4.7).

**Table 4.7: Intended Outputs, 2006/07**

| Health Problem | National Minimum Standard Outputs | Area of intervention to attain output |
|---|---|---|
| 1. High rates of under fives and maternal mortality | 1.1 50% of staffs are retrained on life saving skills and focus ante natal care | Obstetric and antenatal care, family planning and child health. |
| | 1.2 All health facilities have basic equipment essential for provision of Reproductive and Child Health (RCH) services | |
| | 1.3 All high risk patients are referred to higher level on time | |
| | 1.4 Mobile out reach services to be provided in all underserved areas | |
| 2. Burden of disease caused by communicable diseases | 2.1 50% of health care providers are trained on good case management practices | Care for management and prevention of TB, HIV and AIDS and febrile illnesses including malaria. |
| | 2.2 Facilities are providing quality care to address TB, HIV and AIDS, malaria, diarrhea diseases according to appropriate national guidelines. | |

| Health Problem | National Minimum Standard Outputs | Area of intervention to attain output |
|---|---|---|
| 3. Lack of community awareness on health promotion and disease prevention | 3.1 50% of households adhere to good hygiene and sanitation practices in squatter areas | Water, hygiene, sanitation and food |
| | 3.2 Reduction of obesity by 10% smoking behavior by 5%, increase physical activities by 15% | |
| 4. Inadequate institutional capacity to organize, manage and channel resources, towards improved health care delivery. | 4.1 CHMT, Health facility, health committees, board and council social welfare committees meetings are conducted according to schedule | Coordination and management, administration supervision evaluation and staff deployment |
| | 4.2 Improved quality of care | |
| | 4.3. Distribution of health workers are done according to manning levels | |
| | 4.4 Ensure regular maintenance and prompt repair | |

The analysis revealed that the achievement of these outputs is not followed through and reported consistently in the annual implementation reports. However, from these reports, one may pick some variables that portray achievement of some of these outputs. For instance;

- *It is reported that "390 staff from health facilities were trained on "new regimes of malaria case management using ALu drug." One would wonder what percentage is this, as we expected 50% of the staff to have got some kind of training on life saving skills.*
- *Distribution of health workers is done according to manning levels; 65 employees of different cadres were recruited to reduce shortage of staff in the department. To gauge achievement, one would expect to see a comparison on what was the target per year with what was expected.*

In addition to these broad outputs, the 2005/06 CCHP provides detailed operational objectives and their budgetary allocations. Evaluation indicators for each operational objectives/activities are also provided. The monitoring and evaluation chapter (chapter seven of the CCHPs) also provides detailed indicators on health service delivery performance monitoring. These show baselines and expected outputs and could be used to measure progress.

Chapters 4 on priority problems and 5 on planned interventions of the three CCHPs are the same (literally word by word). Tables 17 (2005/06 CCHP), 20 (2006/07 CCHP) and 20 (2007/08 CCHP) describes interventions for respective years. Although one may ague that priorities may not change in the short run given the demanding need of the health sector, one would expect the outputs to change given the investment directed to the sector. For example, in solving the problem related to high rates of under fives and maternal mortality one of the output to be reached for the year is *"50% of staffs are trained on the life saving skills and focus on ante natal care."* This output has been repeated in the three CCHPs.

- *Thus, we expect these outputs to change year after year given the investment in the sector. If no change is noted, it is also important to explore why*.

The following two major management related problems have also been raised in the three reviewed CCHPs:

- Shortage of appropriate skills in administrative services at the municipal hospital level, health centres, and dispensaries.
- Lack of appropriate skills in health planning and evaluation of plans at the dispensary level.

These problems have been reported in the 2005/06 CCHP and subsequent CCHPs (2006/07 and 2007/08).

- *These problems are addressed through allocation of funds to interventions under problem area number 4:* ***"Inadequate institutional capacity to organize, manage and channel resources towards improved health care delivery."*** *One would have expected to see a NOTE in each subsequent CCHP on improvements in management practices. If no improvement has been noted the reasons have to be given, and a brief note on what have been the implications of these weaknesses in implementing the CCHPs.*

Chapter seven of each CCHP report the Monitoring and Evaluation indicators. These indicators are based on the National Minimum Standards (NMS). A thorough scrutiny of these chapters shows that the same remarks have been pointed out; even in areas when they do not hold. There is a notable improvement in the indicators for council health service delivery as reported in these chapters. However, copying and pasting without thorough review was also observed in these chapters. For example, there is increase in proportion of clients attending for purposes of deliveries. This increased from 43.1% in 2002 (baseline) to 98% in 2004 (CCHP 2005/06). The table remarks that hospital deliveries increased due to

increased number of health facilities (government) conducting deliveries. This remark has been repeated in the subsequent CCHPs even where there is a decline in number of clients. For instance, the number of clients was 98.8% in 2005/06 but declined to 91.7% but the same remark persisted. Other remarks that persisted in the three CCHPs is "the percent of those received $TT_2$+ was 89.4% and most of new born are underweight (2.5 kg) due to HIV and AIDS."

- *These remarks make one wonder whether the CCHP drafting team make a follow up to get appropriate explanations for the trends. For sure it is not convincing that the same percent of women (89.4%) received $TT_2$+ in the three consecutive years. Further, given the advent of ARV, we do not expect the same result for three years with regard to the weight of new born.*

The 2005/06 CCHP have indicated data problems that come from the review of reports and facility-based data which suffer from statistical and/or methodological errors. The problems include reliability, reproducibility, and generalizalibility of the results and its interpretation and whether the data are appropriate to influence decision-making. The CCHP further pointed out that the Municipality has started to lay down some strategies such as:

- Re-establishing baseline data though improved HMIS data collection, reporting and analysis
- Working closely with the National Sentinel Surveillance System under Ministry of Health to adopt and expand the demographic and mortality surveillance activities, which are currently performed by the Adult and Morbidity and Mortality Project (AMMP).
- Investing in and conducting operational research at municipal and facility levels to describe effectiveness of specific interventions performed.

- *These strategies have repeatedly been reported in the 2006/07 and 2007/08 CCHPs. This implies that nothing has been done to address data related problems.*

### 4.2.4 Public Integrity Processes

Major issues in district specific public integrity processes are existence of mechanisms to prevent the misuse/abuse of public resources, and the capacity to respond to cases of misuse and/or abuse of public resources. It is worth noting that the CCHPs and annual implementation reports are tools that guide the planning, budgeting, and implementation processes and they do not reflect the mechanisms to oversee the use of resources. The

Auditor and Controller General Report on financial statement can shade some light on public integrity processes as it points out the case of misuse of misappropriation of funds.

Several issues have been raised in Report of the Controller and Auditor General on the Financial Statement of Ilala Municipal Council for the financial year ended 30th June 2005. However, two are addressed here;

- Some queries raised in year 2004 audit report have not been addressed by February 2006 when the mentioned auditing was conducted (Table 4.8).
- The audit team experienced delays in getting documents from the management.

**Table 4.8: Queries from the Auditor Report**

| Financial Year | Queries issued | Queries closed | Outstanding queries |
|---|---|---|---|
| Jan to June 2004 | 47 | 42 | 5 |
| 2004/05 | 59 | 29 | 30 |
| **Total** | **106** | **71** | **35** |

➢ *Thus, the district management has been urged to address the queries before the next audit. Further, district financial reports have to be freely available not only to the audit team but the whole public.*

### 4.2.5 Informed and Improved Planning

There is no evidence to suggest that there is consequent informed planning, that is, incremental planning whereby last year's Plan inform the subsequent Plan. As pointed above, Chapters 4 on priority problems and 5 of planned interventions of the three CCHPs are the same; Tables 17 (2005/06 CCHP), 20 (2006/07 CCHP) and 20 (2007/08 CCHP) describes interventions for respective years. Although one may argue that priorities may not change in the short run given the demanding need of the health sector, one would expect the outputs to change given the investment directed to the sector. Further the 2005/06 CCHP have indicated data problems that come from the review of reports and facility-based data which suffer from statistical and/or methodological errors and strategies to address these problems. However, these strategies have repeatedly been reported in the 2006/07 and 2007/08 CCHPs, implying that nothing has been done to address data related problems.

➢ *It is imperative to build on previous CCHPs in order to gauge the achievements and challenges faced in the preceding year, and thus plan realistically.*

## 4.3 Major Conclusions and Issues of Concern

The following are major conclusions and issues of concern noted from the review.

***Major conclusions***

1. There is an increased nominal budget allocation in the three years but the real allocations remained constant in the 2007/08 FY when compared to 2006/07 FY.

2. Increase in the nominal cost sharing fund over time is a positive trend which could be taken to mean that health users are starting to accept that health financing is the responsibility of both the state and citizens.

3. Separating PE from OC is also a positive move; one can know exactly what money from block grant was used for actual interventions.

4. The central government through the block grant (for OC and PE) remains the main source of funds for the Municipal health interventions.

5. The three CCHPs show the allocations to allowances and fuel to be within the allocated ceiling.

***The following are issues of concern:***

1. There is a notable increase in the PE from 2006/07 which is not commensurate with the trend in OC allocation which has remained constant in the two financial years. The implication is that no improvement is seen from the central government for the OC allocations which affects implementation of priority interventions. This leaves funding of interventions on the hands of development partners through basket funding and Municipal own sources.

2. The allocated resources in the previous years have been recorded as received funds in the next year implying that the budget is the same as actual (only basket grants allocations differ in 2006/07). This is questionable in particular for the funds that are not predictable, for instance, cost sharing funds.

3. Errors in reporting: funds from sources as reported in the executive summary do not match with what is reported in the text.

4. Other sources are not defined. A footnote explaining what these other sources of funds are will be enlightening.

5. The balance brought down as unspent funds in the previous years are not indicated in the CCHPs. For consistency, this has to be included in the CCHPs when determining funds available for the planning year.

6. In order to enhance transparency, we propose that CCHPs should show the ceiling allowed per cost centre and provide explanation whenever the allocations deviate form the allowed ceiling.

7. Inconsistencies were noted between the figures reported in the Annual Implementation Report (2006/07) and the figures reported in the 2007/08 CCHP as funds collected in the 2006/07.

8. The achievement outputs have not been quantified to show achievement per year. One would expect to see for instance the percentage of the staff trained and whether the figure is close to the target of 50%. This is also applicable to the manning of the health facilities. To gauge achievement, one would expect to see a comparison on what was the target per year with what was achieved.

9. National Minimum Standard outputs presented in chapter five were the same for the three years under review. We expect these outputs to change year after year given the investment in the sector. If no change is noted, it is also important to explore why.

10. Major management related problems have also been raised in the three reviewed CCHPs. However, in the subsequent CCHP no information is presented on improvements in management practices given the investment directed to address these problems. If no improvement has been noted, the reasons have to be documented and also a briefly note on what have been the implications of these weaknesses in implementing the CCHPs should be provided. Further, the same data problems and strategies to address them have repeatedly been reported in the 2006/07 and 2007/08 CCHPs. This either implies that nothing has been done to address data related problems or no impact assessment has been done to determine what more needs to be done.

11. Some audit queries were still pending at the time of 2006 auditing. The district management has been urged to address the queries before the next audit. Further, district financial reports have to be freely available not only to the audit team but the whole public.

12. There is no evidence that the subsequent CCHPs build on the previous ones. It is imperative to build on previous CCHPs in order to gauge the achievements and challenges faced in the preceding year, and thus plan realistically.

# 5.0 TEMEKE MUNICIPAL COUNCIL

## 5.1 Introduction

The Temeke Municipality is one of the three Municipalities in Dar es Salaam region with an estimated population of 886,529[8] (residing in 48,219 households) as projected from 2002 census and an annual increase rate of 2.9 percent in 2007. Table 5.1 shows the vital statistics for the district.

**Table 5.1: Vital Statistics**

| Sn. | Variable | Value |
|---|---|---|
| 1. | Total population | 886,529 |
| 2. | Population growth rate (%) | 2.9 |
| 3. | Crude Births Rate | 40/1000 |
| 4. | Crude Death Rate | 15/1000 |
| 5. | Children <1 year (4%) | 35,461 |
| 6. | Children <5 year (20%) | 177,306 |
| 7. | Women: 15-49 years (18%) | 159,575 |
| 8. | Maternal mortality | 2/100,000 |
| 9. | Population per nursing staff | 1/2,360 |
| 10. | Population per physician | 1/35,898 |
| 11. | Population per health facility | 1/8,863 |
| 12. | Percent of population with access to health facility within 5 km radius | 90 |

The mode of health service delivery in Temeke Municipal Council is based on curative, preventive and promotive health care and rehabilitative services provided by either private or government owned health facilities. These include hospitals, health centres and dispensaries.

In 2004, the top five diseases in the Municipal were found to be malaria, acute respiratory infections, pneumonia, diarrhoea diseases and anaemia. In 2005, malaria, pneumonia, acute respiratory infections, and diarrhoea diseases remained on the list of the top five diseases plus urinary tract infection**.** In 2006, the top five diseases in the Municipal were found to be malaria, acute respiratory infection, diarrhoea, pneumonia, and urinary tract infection.

[8] Note that the population reported in the text (page 7) is different from the total recorded in Table 1.2.2 (page 9).

Temeke plan of activities has been organized under five major strategies at all levels. These include improving;

- Management and coordination; this takes into account all activities pertaining to management and coordination within the health service delivery.
- Management of resources improved.
- Planning monitoring, supervision and evaluation.
- Program services: Under this strategy, there is all health activities directed to improvement of curative, preventive and promotive services. These include; private facility support services, Reproductive and Child Health services, drugs services, investigation services, communicable and non-communicable disease control services. Others are community based health care services, Information, Education and Communication services, and environmental hygiene and sanitation services.

## 5.2 Analysis of CCHPs and Technical and Financial Reports

### 5.2.1 Planning and Resource Allocation

Analysis of CCHPs was done to gauge the available financial and non-financial resources for delivery of health services. Table 5.2 shows the trends in budgetary allocations from different sources for health services delivery in the Temeke Municipality. There is notable increase in the nominal budget allocation in the three years except for two items; funds from the Municipal Director and other sources which increased sharply in 2006/07 but declined in 2007/08. In nominal terms, the budget increased by 81% in FY 2006/07 (base year is FY 2006/07) but in FY 2007/08 the increase was only 29.5% (base year is 2006/07). For all the years, reporting of block grant has been separated into OC and PE which means one can know exactly what money from block grant was used for actual interventions. While the PE more than tripled from 2006/07 to 2007/08, the OC has remained constant. There is notable increase in the cost sharing funds. The increase 31% from 2005/06 to 2006/07 but increased by 37.2% from 2006/07 to 2007/06.

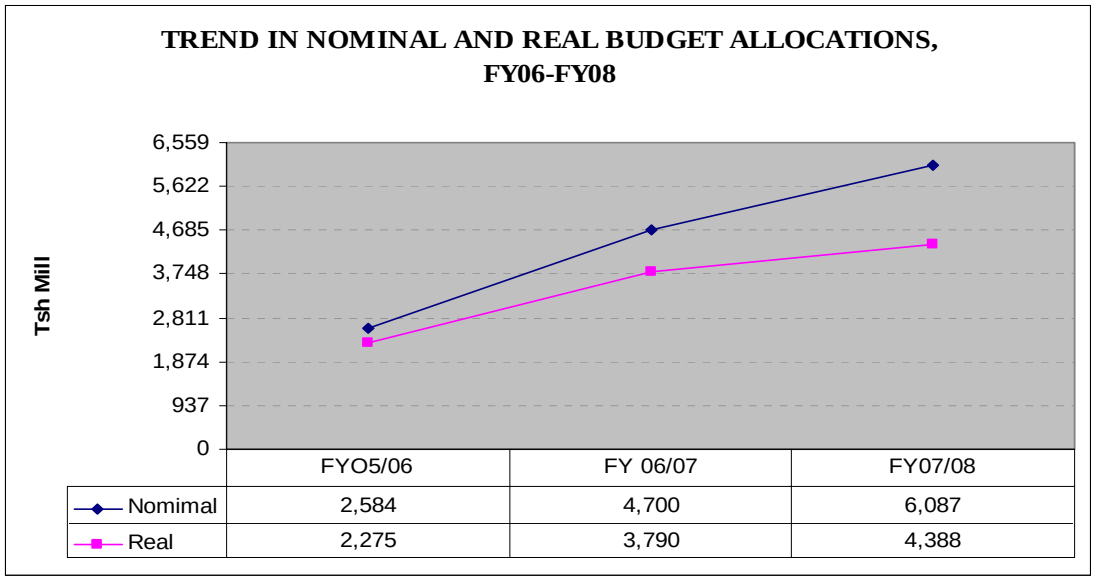
- *Increase in the cost sharing fund over time is a positive trend which could be taken to mean that health users are starting to accept that health financing is the responsibility of both the state and citizens.*
- *Separating PE from OC is also commended; one can know exactly what money from block grant was used for actual interventions.*

**Table 5.2: Funds from Various Sources (TShs)**

| Sn. | Source of Funds | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|
| 1. | Cost sharing funds | 293,486,973 | 385,391,661 | 528,937,152 |
| 2. | Basket fund | 377,569,900 | 446,658,000 | 866,389,000 |
| 3. | Municipal Council | 20,783,974 | 28,684,614 | 23,625,000 |
| 4. | Block grant for PE/Salary | 1,068,222,349 | 2,822,211,914 | 3,581,376,018 |
| 5. | Block grant for OC | 322,469,651 | 322,000,000 | 355,814,538 |
| 6. | Receipt in kind (drugs) | 400,260,000 | 352,971,266 | 714,907,431 |
| 7. | Other Source | 101,610,000 | 342,276,250 | 15,773,001 |
| | **Total** | **2,584,402,847** | **4,700,193,705** | **6,086,822,140** |

Figure 5.1 compares the nominal increase versus real increase in allocations for the past three years. As the figure portray, in both nominal and real terms, there is a notable increase in the budget from 2005/06 to 2007/08. However, the difference between the nominal and real budget is high in 2007/08 period due to high Consumer Price Index.

**Figure 5.1: Trend in Nominal and Real Budget Allocation**




Source: CCHP 2005/06; 2006/07; 2007/08
Note: The Consumer Price Indices (CPI) used: 2005/06=113.6; 2006/07=124; 2007/8=138.7.

Table 5.3 shows the percent contribution of each type of funding source. Although nominally the cost sharing funds has increased, it has declined as the percent of the total budgetary allocations for 2006/07 and 2007/08. The basket funds budget declined in 2006/07 but it picked up in 2007/08. The allocations from the Municipal Council remained constant in the three years period. The PE takes the largest share of allocations and it has increased substantially over the three years under review.

**Table 5.3: Percent Contribution of Each Type of Funding Source**

| Sn. | Source of Funds | 2005/06 | % of total | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|---|---|---|
| 1 | Cost sharing funds | 293,486,973 | 11 | 385,391,661 | 8 | 528,937,152 | 9 |
| 2 | Basket fund | 377,569,900 | 15 | 446,658,000 | 10 | 866,389,000 | 14 |
| 3 | Municipal Council | 20,783,974 | 1 | 28,684,614 | 1 | 23,625,000 | 0.4 |
| 4 | Block grant for PE | 1,068,222,349 | 41 | 2,822,211,914 | 60 | 3,581,376,018 | 59 |
| 5 | Block grant for OC | 322,469,651 | 12 | 322,000,000 | 7 | 355,814,538 | 6 |
| 6 | Receipt in kind (drugs) | 400,260,000 | 15 | 352,971,266 | 8 | 714,907,431 | 12 |
| 7 | Other Source | 101,610,000 | 4 | 342,276,250 | 7 | 15,773,001 | 0.3 |
| | Total | 2,584,402,847 | 100 | 4,700,193,705 | 100 | 6,086,822,140 | 100 |

The following are issues arising from the analysis:

- *The central government through the block grant (for OC and PE) remains the main source of funds for the Municipal health interventions.*

- *There is a notable increase in the PE from 2005/06 to 2007/08 (more than 200 percent increase). This is however not commensurate with the trend in OC allocation; this has remained constant in the three financial years under review. The implication is that no improvement from the central government for the OC which affects implementation of priority interventions. This leaves funding of interventions on the hands of development partners through basket funding, and other sources and Municipal own sources.*

- *Errors in reporting; for instance, on page 6 of 2007/08 CCHP, the Other Sources allocations as the percent of the total allocations is reported to be 16.3 percent. This is not a correct figure. The same goes for other percentages reported in the table. As much as this can be termed as a human error, efforts have to be made to avoid such human errors in the future.*
- *In the 2005/06 and 2006/07 CCHPs the other sources of funds have been defined but this has not been done in the 2007/08 CCHPs. A footnote explaining what these other sources of funds are will be illuminating.*

### 5.2.2 Effectiveness and Efficiency of Expenditure Management

Comparisons were made between the budgetary allocations as reported in the CCHPs and the actual received funds (Table 5.4). Consistently, in all the three CCHPs, the last year referred to was not the preceding financial year but the year before the preceding year. For instance, in the 2007/08 CCHP, the last year was reported to be July 2005 to June 2006. This kind of reporting is only prevalent in Temeke CCHPs.

Given this reporting weakness (check the guideline), it has only been possible to get the actual funds collected and the funds for the planning period for only one year (Table 5.4). The 2005/06 CCHP did not report the funds collected in the past year but only the funds collected in the first two quarters and the January to February 2005. This was corrected in the following CCHPs which apart from reporting the funds received in the first two quarters of the last year it also reported the funds reported in the "past year" although not really the past year as reported above.

- *Under the cost sharing, there is source of funds named "other health facility" which is shown to be different from hospitals, health centres, and dispensaries. This is consistently reported in all the three CCHPs. The funds from "other health facilities" are substantial for instance; they contributed to 33.5 percent of the total cost sharing budget in 2005/06 planning period and 100 percent in the 2007/08 planning period. It is imperative to know what these other health facilities are*[9].

- *The Annual Implementation Report (2006/07) only reported the budgeted and received funds for the last quarter (April –June 2007). Thus, it has been difficult to compare the actual allocations with what is presented in the 2007/08 CCHP as the data are not available. The financial report has only reported annual allocations for the basket grant only. This is a big anomaly. An annual implementation report can not only report quarterly expenditures; annual expenditures have to be reported. Up to page 94 is only quarterly reporting. From page 95 we see a summary of health sector recurrent account system (yearly budget and quarterly budgets which is also reported in other implementation plans (see Ilala MC, Kinondoni MC and Kibaha DC plans) but after thorough presentation of source of funds, the expenditures on different cost centres and activities implemented per year.*

**Table 5.4: Budgetary Allocations versus Actual funds Received**

[9] Discussions with the district health officials revealed that these facilities are health centers and dispensaries. To avoid future confusions, these other health facilities should be defined right away.

| Source of funds | Allocated for the planning period (2005/06)* | Received/ collected (2005/06)** |
|---|---|---|
| Block grant (PE) | 1,068,222,349 | 1,306,546,966 |
| Block grant (OC) | 243,565,151 | 282,446,460 |
| Council own resources (Recurrent) | 20,783,974 | 28,850,000 |
| Council own resources (Development) | 0 | 0 |
| Basket grants | 377,569,900 | 377,569,900 |
| Cost sharing (hospital, other health facility, health centre, dispensary) | 293,486,973 | 335,385,401 |
| Receipt in kind (drugs, other) | 400,260,000 | 359,388,960 |
| Vertical Programs | | |
| *MoH PMTCT* | - | *75,051,336* |
| *NTLP* | - | *25,660,600* |
| *LHL* | *77,706,000* | *117,061,065* |
| *UNICEF* | - | *0* |
| *GLOBAL* | - | *50,247,554* |
| *CLITON FUND* | - | *19,203,400* |
| *NIMRI* | *40,000,000* | *57,870,000* |
| **Grand Total** | **2,521,594,347** | **3,049,329,206** |

* Reported in the 2005/06 CCHP pp 27-28.
** Reported in the 2007/08 CCHP p 46.

Examination of allocations per cost centres show that the municipal hospital takes a big chunk of the municipal health funds (above 45% in 2005/06 and 2006/07) [Table 5.5]. In 2005/06 MMOH took the largest share of the total expenditures (31%) compared to Municipal Hospital (29%). In all the three years, the next big spender is municipal dispensary (≤ 20% of the total budget). The three CCHPs show the allocations to allowances and fuel to be within the allocated ceiling.

**Table 5.5: Budget Allocations per Cost Centre**

| Cost Centre | 2005/06 | % of total | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|---|---|
| MMOH | 812,659,305 | 31 | 851,608,334 | 18 | 252,268,351 | 4 |
| Municipal Hospital | 755,997,775 | 29 | 2,184,729,838 | 46 | 2,851,833,002 | 47 |
| Rural Health Centre | 308,436,987 | 12 | 593,689,151 | 13 | 864,420,508 | 14 |
| Mini Hospital Vijibweni | - | 0 | 95,585,800 | 2 | 573,961,663 | 9 |
| Municipal dispensary | 654,370,653 | 25 | 929,914,782 | 20 | 1,425,501,716 | 23 |
| Community | 52,938,126 | 2 | 44,665,800 | 1 | 118,836,900 | 2 |
| **Total** | **2,584,402,847** | 100 | **4,700,193,705** | 100 | **6,086,822,140** | 100 |

Table 5.6 shows trends in allocation of Basket Fund per cost centre. The Table shows that almost the same proportion of the funds have been allocated to the cost centres for the three years except for Municipal Hospital in 2005/06. Although the CCHPs did not provide the ceiling allowed per each cost centre, the 2005/06 and 2006/07 CCHPs provided explanation for any discrepancy from the allowed ceiling. For instance, in 2005/06 CCHP, it is indicated that due to the fact that there is no voluntary agency facilities in the municipality, primarily the Municipal Hospital offers second line services however it also offers first line services to the near-by densely populated areas since there are no public dispensaries. Due to these reasons the hospital has been allocated 37% instead of 35% which is allowed budget ceiling. The same explanation has been provided in the 2006/07 CCHP. Due to additional facility (Vijimweni Mini Hospital) Temeke Hospital has been allocated 30% instead of 35% allocation. However, despite this explanation, no allocation for a mini hospital is reported on the table in page ix. No explanation has been provided in the 2007/08 CCHP although its shows allocation for the mini hospital. There is consistency on the data reported in Table 4.5 with data presented in the Annual Technical and Financial Report for the period 1st July 2006 to 30th June 2007.

- *In order to enhance transparency, we propose that CCHPs should show the ceiling allowed per cost centre (as observed in the 2005/06 and 2006/07 CCHPs) and provide explanation whenever the allocations deviate form the allowed ceiling.*

**Table 5.6: Trends in Allocation of Basket Fund per Cost Centre**

| Cost Centre | 2005/06 | % of total | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|---|---|
| MMOH | 56,635,485 | 15 | 66,998,700 | 15 | 129,955,350 | 15 |
| Municipal Hospital | 140,531,516 | 37 | 133,997,400 | 30 | 259,930,700 | 29 |
| Municipal Health Centre | 56,635,485 | 15 | - | - | 129,955,350 | 15 |
| Urban Health Centre | - | - | 66,998,700 | 15 | - | - |
| Rural Health Centre | - | - | 44,665,800 | 10 | - | - |
| Mini Hospital | - | - | - | - | 86,636,900 | 10 |
| Municipal Dispensary | 86,010,424 | 23 | 89,331,600 | 20 | 173,273,800 | 20 |
| Community | 37,756,990 | 10 | 44,665,800 | 10 | 86,636,900 | 10 |
| **Total** | **377,569,900** | 100 | **446,658,000** | 100 | **886,389,000** | 100 |

Note: MMOH=Municipal Medical Office of Health

In the 2005/06 CCHP allocated funds are shown by priority area; at least for the basket fund. The priority areas include reproductive and child health, communicable diseases, non-communicable diseases, community health promotion and disease prevention and administration (Table 5.7). Administration took more than 60% of the total allocation in the referred period. This kind of presentation has however not been carried over in the subsequent CCHPs.

- *It is imperative to continue providing the information on allocations per priority areas in order to gauge the extent at which the budget allocations reflect health priorities in the Council, and whether there improvements in spending for priority interventions versus administration.*

**Table 5.7: Allocation of Funds by Priority Areas**

| Sn. | Intervention | Total Budget | % of the total |
|---|---|---|---|
| 1. | Reproductive and child health | 40,313,971 | 11 |
| 2. | Communicable diseases | 57,658,536 | 15 |
| 3. | Non-communicable diseases | 11,896,950 | 3 |
| 4. | Community health promotion and disease prevention | 25,295,490 | 7 |
| 5. | Administration | 242,404,950 | 64 |
| | **Total** | **377,569,897** | **100** |

Source: CCHP (2005/06).

Although delays in disbursement have been reported in the Annual Financial and Technical Report (2006/07), there is no evidence of dumping of funds in the last quarter. It is reported in this report that delay in funds is one of the reasons that hinder smooth implementation of the Municipal activities. For instance, the first and second quarter funds from the Basket were received at the end of September 2006 which contributed to the delay in the implementation of the planned activities in the other quarter of 2006/07.

### 5.2.3 Performance Management

Assessment of the annual implementation reports show that almost all activities were fully implemented except few activities. The few activities that were not implemented were attributed to delay of funds. For instance, the first and second quarter funds from the Basket were received at the end of September 2006 which contributed to the delay in the implementation of the planned activities. The cash book balance at the end of the period (30.06.2007) was TShs 111,713,722; this means that this sum was not available on time for implementation of the planned activities and this money has been carried over to the next financial year (2007/08).

Table 5.1 of the 2006/07 CCHP (page 34-39) describes the health problems in focus, the long term objectives/the output to be achieved and areas of interventions to achieve the outputs. The analysis revealed that the achievement of these outputs is followed through chapter 7 on performance and monitoring indicators achievement. However, the indicators tracked in chapter seven are the required minimum standards indicators and not necessary the ones that are Municipal specific, for instance, increase in HMIS reporting rate from 67% to 80% for private and sustain it at 100% for public facilities is a district specific indicator that achievement has not been reported.

- *The need to follow up and report on Municipal specific indicators is of the essence. This is because these indicators are localized and it is important to achieve them for increased efficiency and effectiveness in the performance of specific Council.*

In addition to these broad outputs, the 2005/06 CCHP provides detailed operational objectives and their budgetary allocations. Evaluation indicators for each operational objectives/activities are also provided. The monitoring and evaluation chapter (chapter seven of the CCHPs) also provides detailed indicators on health service delivery performance monitoring. These show baselines and expected outputs and could be used to measure progress.

Chapters 5 are named as planned interventions in 2005/06 and 2006/07 CCHPs and renamed objectives, targets, and planned interventions in 2007/08 CCHP. The information presented in these chapters on the long term objectives and interventions (Tables 5, CCHP 2007/08 does not indicate table number) are the same (literally word by word). Although one may ague that long term objectives are to be achieved in the long run, and that priorities may not change in the short run one would expect the expected achievement (in %) of the long term objectives to change over time, given the investment in the sector. For example, one of the problems identified in all the three CCHPs is low proportion of women attending for antenatal care. The long term objective to be achieved is *"proportion of women attending for antenatal clinic increased from 90% to 92%.*This long term objective has been repeated in the three CCHPs.

- *Thus, we expect these long term objectives to change year after year given the investment in the sector. If no change is noted, it is also important to explore why*.

As pointed above, chapter seven of each CCHP report the Monitoring and Evaluation indicators. These indicators are based on the National Minimum Standards (NMS). Except for "no data" remark, no other remarks have been provided even where the target has been surpassed or performance has been poor.

- *We expect a remark on exceptional performance in order to learn from the best practices contributing to that achievement and also explanation where the target has not been reached.*

- *The 2007/08 CCHP does not have the chapter on performance indicators although in the Table of content is it indicated that this information is available on page 190. On page 190, only information on assumptions and risks is presented. Nevertheless, it is not clear what the Table of Contents presents as labeling of the chapters in the document is not consistent with what is presented in the Table of Contents. The same is observed for the 2006/07 CCHP.*

### 5.2.4 Public Integrity Processes

Major issues in district specific public integrity processes are existence of mechanisms to prevent the misuse/abuse of public resources, and the capacity to respond to cases of misuse and/or abuse of public resources. It is worth noting that the CCHPs and annual implementation reports are tools that guide the planning, budgeting, and implementation processes and they do not reflect the mechanisms to oversee the use of resources. The

Auditor and Controller General Report on financial statement can shade some light on public integrity processes as it points out the case of misuse of misappropriation of funds.

During the audit of the current year's accounts, the auditors reviewed implementation of audit recommendations of the outstanding matters of the 2004 audit report. They noted with satisfaction that the Management has implemented most of the audit recommendations except for the following few which were observed to have not been fully implemented (Table 5.8). However, the queries raised in 2005 audit report have not been satisfactory addressed. There were 18 audit outstanding queries and further 18 revenue un-produced receipt books. Other issues raised are presented in Table 5.9. These include the existence of long time outstanding debtors.

- *Failure to address auditing query on time is a weakness that need to be corrected.*
- *The implication of the existence of long time outstanding debtors is a clear sign of a weakness on the part of management to effectively manage this important Council asset (debtors).*

**Table 5.8: Outstanding Auditor Queries**

| Year | Para | Description | Amount still outstanding TShs |
|---|---|---|---|
| 2004 | 5.2.1 | Un-cleared revenue debtors | 47,725,840 |
| 2004 | 5.2.2 | Outstanding other debtors | 128,263,147 |
| 2004 | 5.2.3 | Sundry creditors not settled | 149,903,943 |
| **Total** | | | **353,395,984** |

**Table 5.9: Other Issues raised by Auditor in 2005**

| Para | Observation | Amount (TShs) |
|---|---|---|
| 3.6 | Payments made without supporting documents | 34,790,990 |
| 3.7 | Missing payment vouchers | 16,537,275 |
| 3.8 | Statutory deductions not acknowledged | 73,846,691 |
| 3.9 | Irregular use of Imprest | 9,000,000 |
| 3.10 | Irregular payments for removal of waste | 53,800,860 |
| 3.11 | Transfer of funds | 17,577,152 |
| 3.12 | Missing compensation schedules | 72,504,000 |
| 3.13 | Questionable payments of House Rent | 14,157,000 |
| 3.14 | Contracts payment lacking contract agreement and bills of Quantities | 141,101,712 |
| 3.15 | Hospital drugs taken on charge before receipt | 8,052,2290 |
| **Total** | | **794,763,954** |

The internal control over custody and issuance of revenue receipts was also found to be weak. It was noted that there was no segregation of duties for custody and issuance of receipt books whereby, the revenue accountant is the one who places orders for printing receipt books, receives, and issues.

- *This is a weakness in accounting for Council's revenue which can encourage fraudulent practices.*
- *Thus, Management should ensure that the functions involving financial transactions are segregated to comply with the requirements of good internal control system.*

There was also unspent balance of Grants for development purposes amounting to TShs 1,419,684,643. Examination of accounts relating to grants disclosed unspent balances of grants on seven (7) Council accounts are detailed in Table 5.10.

**Table 5.10: Unspent Balances of Grants on Seven Council Accounts**

| SN. | Account Name | Total Receipts | Total Payments | Closing Balance |
|---|---|---|---|---|
| 1 | Unplanned settlements | 102,754,819 | 52,216,750 | 50,538,069 |
| 2 | Road Toll | 500,379,874 | 376,790,283 | 123,589,591 |
| 3 | Health | 2,474,533,025 | 2,319,543,489 | 154,989,535 |
| 4 | Education | 6,738,357,844 | 6,722,807,603 | 15,550,241 |
| 5 | L.G.C.D.G | 1,108,883,300 | 276,150,002 | 832,733,298 |
| 6 | C.I.U.P. | 277,889,540 | 182,965,750 | 94,923,790 |
| 7 | Development | 3,227,890,720 | 3,080,530,603 | 147,360,117 |
| **Total** | | | | **1,419,684,643** |

- *The unspent balances of grants indicate that the approved development activities were partially or not implemented at all.*
- *It is recommended that efforts should be made to ensure that development activities are timely implemented as indicated in the work plan.*

### 5.2.5 Informed and Improved Planning

There is no evidence to suggest that there is consequent informed planning, that is, incremental planning whereby last year's Plan inform the subsequent Plan. As pointed above, Chapters 5 are named as planned interventions in 2005/06 and 2006/07 CCHPs and renamed objectives, targets, and planned interventions in 2007/08 CCHP. The information presented in these chapters on the long term objectives and interventions are the same (literally word by

word). Although one may ague that long term objectives are to be achieved in the long run, and that priorities may not change in the short run given the investment in the sector, one would expect the expected achievement percent wise of the long term objectives to change over time.

- *It is imperative to build on previous CCHPs in order to gauge the achievements and challenges faced in the preceding year, and thus plan realistically.*

## 5.3 Major Conclusions and Issues of Concern

The following are conclusions and issues of concern noted from the review.

***Major Conclusions***

1. There is a notable budget increase in both nominal and real terms from 2005/06 to 2007/08. However, the difference between the nominal and real budget is high in 2007/08 period due to high Consumer Price Index.

2. Increase in the cost sharing fund over time is a positive trend which could be taken to mean that health users are starting to accept that health financing is the responsibility of both the state and citizens. However, cost sharing has declined as the percentage of the total budgetary allocations for 2006/07 and 2007/08.

3. Separating PE from OC is commended; one can know exactly what money from block grant was used for actual interventions.

4. The central government through the block grant (for OC and PE) remains the main source of funds for the Municipal health interventions.

***Issues of Concern***

1. There is a notable increase in the PE from 2005/06 to 2007/08 (more than 200 percent increase). This is however not commensurate with the trend in OC allocation; this has remained constant in the three financial years under review. The implication is that no improvement from the central government for the OC which affects implementation of priority interventions. This leaves funding of interventions on the hands of development partners through basket funding, and other sources of funds and Municipal own sources.

2. The funds from Municipal Council have remained low and constant in the three years. This can be interpreted as lack of the Municipal policy makers and planners to make health a priority area of spending in the Municipality.

3. There are several errors in reporting budget allocations and vital statistics, for instance, page 6 of 2007/08 CCHP, the other sources allocations as the percent of the total allocations is reported to be 16.3 percent which is a wrong figures. These errors ought to be corrected.

4. In the 2005/06 and 2006/07 CCHPs the other sources of funds have been defined but this has not been done in the 2007/08 CCHPs. Definition of other sources of funds should be provided in every CCHP.

5. The balance brought down as unspent funds in the previous years are not indicated in the CCHPs. For consistency, this has to be included in the CCHPs when determining funds available for the planning year as these are sources of funds.

6. Under the cost sharing, there is source of funds named "other health facility" which is shown to be different from hospitals, health centres, and dispensaries. This is consistently reported in all the three CCHPs. It is imperative to know what these other health facilities are.

7. The Annual Implementation Report (2006/07) only reported the budgeted and received funds for the last quarter (April –June 2007). Thus, it has been difficult to compare the actual allocations with what is presented in the 2007/08 CCHP as the data are not available. In the substantive chapters of the report, the financial report has only reported annual allocations for the basket grant only.

8. In order to enhance transparency, we propose that CCHPs should show the ceiling allowed per cost centre (as observed in the 2005/06 and 2006/07 CCHPs) and provide explanation whenever the allocations deviate from the allowed ceiling.

9. In the 2005/06 CCHP allocated funds are shown by priority area; at least for the basket fund. This kind of presentation has however not been carried over in the subsequent CCHPs. It is imperative to continue providing the information on allocations per priority areas in order to gauge the extent at which the budget allocations reflect health priorities in the Council, and whether there are improvements in spending for priority interventions versus administration.

10. Reporting for NMS indicators is provided in all the CCHPs. However, no follow up of district specific indicators is shown. The need to follow up and report on Municipal

specific indicators is of the essence. This is because these indicators are localized and it is important to achieve them for increased efficiency and effectiveness in the performance of specific Council. Further, we expect a remark on exceptional performance in order to learn from the best practices contributing to that achievement and also explanation where the target has not been reached.

11. The 2007/08 CCHP does not have the chapter on performance indicators although in the Table of content is it indicated that this information is available on page 190. Further, it is not clear what the Table of Contents presents as labeling of the chapters in the document is not consistent with what is presented in the Table of Contents. The same is observed for the 2006/07 CCHP.

12. The Audit Reports indicates;
    a. Failure of the Municipal to address the auditing query on time; this is a weakness that needs to be corrected.
    b. The existence of long tome outstanding debtors. The implication of the existence of long time outstanding debtors is a clear sign of a weakness on the part of management to effectively manage this important Council asset (debtors).
    c. No segregation of duties for custody and issuance of receipt books. This is pointed out to be a weakness in accounting for Council's revenue which can encourage fraudulent practices. Thus, Management should ensure that the functions involving financial transactions are segregated to comply with the requirements of good internal control system.
    d. Unspent balances of grants which means that the approved development activities were partially or not implemented at all. It is recommended that efforts should be made to ensure that development activities are timely implemented as indicated in the work plan.

13. There is no evidence to suggest that there is consequent informed planning. It is of the essence to build on previous CCHPs in order to gauge the achievements and challenges faced in the preceding year, and thus plan realistically.

# 6.0 KINONDONI MUNICIPAL COUNCIL

## 6.1 Introduction[10]

The Kinondoni Municipal Council is one of the three Municipalities in Dar es Salaam region with estimated population of 1,088,867 as projected from 2002 census with an annual increase rate of 4.3% per annum. When compared with Temeke and Ilala it has largest population among the three Councils. Table 6.1 shows the vital statistics for the Council.

**Table 6.1: Vital Statistics, Kinondoni Municipal Council**

| Sn. | Variable | Value |
|---|---|---|
| 1. | Total population | 1,088,867 |
| 2. | Population growth rate (%) | 4.1 |
| 3. | Crude Death Rate | 143/1000 |
| 4. | Children <1 year (%) | 4 |
| 5. | Children <5 year (%) | 21 |
| 6. | Women: 15-49 years (%) | 18 |
| 7. | Infant mortality rate | 115/1000 |
| 8. | Underfive mortality | 153/1000 |
| 9. | Population per nursing staff | 1:6,593 |
| 10. | Population per physician | 1:73,622 |
| 11. | Population per health facility | 1:7,661 |
| 12. | Percent of population with access to health facility within 5 km radius | 75 |

Source: CCHP 2007/08.

It is important to note that in reporting the district vital statistics in some cases the national figures are mixed with HMIS figures and one can not tell which is which. This is in particularly so with population and mortality rate figures. Further, different figures are reported without necessarily reporting the source. For example, the annual population growth rate reported on page 21 of the 2007/08 CCHP is different from what is reported on page 18 and even the population figure reported on page 22 of the same report is different.

- *It is important to report the sources of the reported figures and whether the figures represent national picture or the district picture using the data generated from the HMIS.*

[10] Only two CCHPs are available for this review: the 2006/07 and 2007/08 CCHPs.

The mode of health service delivery in Kinondoni Municipal Council just like the other reviewed Dar es Salaam Municipal Councils is based on curative, preventive and promotive health care and rehabilitative services provided by either private or government owned health facilities. These include hospitals, health centres and dispensaries.

In 2005, the top five diseases in the Municipal were found to be malaria, acute respiratory infection, HIV & AIDS, pneumonia, and urinary tract infection. The same diseases and in the same order were the main health problems in 2006.

## 6.2 Analysis of CCHPs and Technical and Financial Reports

### 6.2.1 Planning and Resource Allocation

Analysis of CCHPs was done to gauge the available financial and non-financial resources for delivery of health services. Table 6.2 shows the trends in budgetary allocations from different sources for health services delivery in Kinondoni Municipality. There is substantial decrease in the nominal budget allocation in the two years in particular for the block grant which has decreased sharply in 2007/08 (more than 100% decrease). In nominal terms, the budget decreased by 26.8% in 2007/08. In the 2006/07 CCHP, the OC and PE have been reported separately which means one can know exactly what money from block grant was used for actual interventions. This was not the case with the 2007/08 CCHP.

- *There is gross arithmetic error in the figures presented in Budget summary (pages 8-10). The total budget in 2007/08 is indicated to be 1,874,239,000 instead of 2,964,239,000.*

- *Another gross arithmetic error is noted on page 13 of 2007/08 CCHP whereby the subtotal of the budget from basket fund for priority area on strengthening organization structures and institutional capacities for improved health management at levels is indicated to be* ***TShs 2,740,543,999*** *instead* ***of TShs 868,295,691****.The reported subtotal is more than the total basket grant (****TShs 1,216,354,000****).*

- *Going by the wrong figure, one would be startled by the substantial decrease in the budget compared to the budget allocations in the 2006/07 CCHP. However, even after correcting the figure, there is still a substantial decrease which deserves explanation.*

- *Separating PE from OC in 2006/07 budget is commended as one can know exactly what money from block grant was used for actual interventions. However, this is not followed through in the 2007/08 budget.*

**Table 6.2: Funds from Various Sources (TShs)**

| Sn. | Source of Funds | 2006/07 | 2007/08 |
|---|---|---|---|
| 1. | Cost sharing funds | 514,186,000 | 509,586,000 |
| 2. | Basket fund | 620,000,000 | 1,216,354,000 |
| 3. | Council | 20,000,000 | 353,550,000 |
| 4. | Block grant for OC and PE | - | 673,609,000 |
| | *Block grant for PE/Salary* | *1,626,307,104* | - |
| | *Block grant for OC* | *733,000,000* | - |
| 5. | Receipt in kind (drugs) | - | 211,140,000 |
| 6. | Ministry of Health | 400,000,000 | - |
| 7. | Other Source | 136,486,000 | - |
| | **Grand Total** | **4,049,979,104** | **2,964,239,000** |

Table 6.3 shows the percent contribution of each type of funding source. Although nominally the cost sharing funds has declined, it has increased as the percent of the total budgetary allocations for 2007/08. There is substantial increase of the allocations from the Basket (which almost doubled from 2006/07 to 2007/08 and in 2007/08 budget it provides the highest share. The concern is with the block grant funds which declined substantially. The share of block grant fund was 58% in 2006/07 budget which declined to 23% in 2007/08 budget.

**Table 6.3: Percent Contribution of Each Type of Funding Source**

| Sn. | Source of Funds | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|---|
| 1 | Cost sharing | 514,186,000 | 13 | 509,586,000 | 17 |
| 2 | Basket fund | 620,000,000 | 15 | 1,216,354,000 | 41 |
| 3 | Council | 20,000,000 | 0 | 353,550,000 | 12 |
| 4 | Block grant | 2,359,307,104 | 58 | 673,609,000 | 23 |
| 5 | Receipt in kind (drugs) | 0 | 0 | 211,140,000 | 7 |
| 6 | Ministry of Health | 400,000,000 | 10 | 0 | 0 |
| 7 | Other Source | 136,486,000 | 3 | 0 | 0 |
| | **Grand Total** | **4,049,979,104** | 100 | **2,964,239,000** | 100 |

The following are issues of concern for the budget allocations:

- *As pointed above, there is gross error in arithmetic which makes some figures presented in the CCHP doubtful. See figures presented in Budget summary (pages 8-10). The total budget in 2007/08 is indicated to be 1,874,239,000 instead of 2,964,239,000.*

- *The central government through the block grant (for OC and PE) was the main source of funds for the Municipal health activities in the 2006/07 budget. However, the block grant decreased substantially in 2007/08. This deserves explanation. For example, what is the implication of decreasing the funds for PE? Is it true that the block grant funds were substantially decreased or there is an error in recording as noted in arithmetics?*

- *Separating PE from OC has not been done in the 2007/08 budget*

- *Whereas other CCHPs such as those for Temeke and Ilala Municipalities reported the allocated resources in the previous years and make a comparison with the funds allocated in the planning periods, this has not been done for both reviewed Kinondoni CCHPs.*

- *The balance brought down as unspent funds in the previous years are not indicated in the CCHPs. For consistency, this has to be included in the CCHPs when determining funds available for the planning year.*

### 6.2.2 Effectiveness and Efficiency of Expenditure Management

Whereas CCPHs of other City Council Municipals show the funds actually received in the last year and the funds for the planning period, both Kinondoni CCHPs do not contain complete data on such information. The information presented on the Table on page 34 of 2007/08 CCHP on fund received last year and the funds allocated for the planning period is incomplete. For example, no funds for the personal emoluments are indicated for the planning period. The Table is incomplete and no totals are provided.

- *Thus, it has not been possible to make comparisons between the budgetary allocations and received funds.*

Information on allocation per cost centre for the whole budget was only available in the 2006/07 CCHP. Examination of these allocations show that the municipal hospital takes a big chunk of the municipal health funds (40% of the total in) [Table 6.4]. The next big spender is municipal dispensary (19% of the total budget). No comparative findings are found in the

2007/08 CCHP. The two CCHPs show the allocations to allowances and fuel to be within the allocated ceiling.

- *It is imperative to report budgets per cost centre not only for the basket grant but also for the total budget. This will help to shade light on the burden of activities at different levels of health care.*

**Table 6.4: Budget Allocations per Cost Centre**

| Cost Centre | 2006/07 | % of total |
|---|---|---|
| MMOH/DMO | 421,973,634 | 10 |
| Hospital | 1,621,898,390 | 40 |
| Health Centre | 589,697,100 | 15 |
| Dispensary | 757,987,980 | 19 |
| Community | 658,422,000 | 16 |
| **Total** | **4,049,979,104** | 100 |

Table 6.5 shows trends in allocation of Basket Fund per cost centre. The Table shows that the same proportions of the funds have been allocated to the cost centres for the two years. However, the reviewed CCHPs do not provide the ceiling allowed per cost centre.

- *In order to enhance transparency, we propose that CCHPs should show the ceiling allowed per cost centre and provide explanation whenever the allocations deviate form the allowed ceiling.*

**Table 6.5: Trends in Allocation of Basket Fund per Cost Centre**

| Cost Centre | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|
| MMOH/DMO | 93,000,000 | 15 | 182,453,100 | 15 |
| Council Hospital | 186,000,000 | 30 | 364,906,200 | 30 |
| Health Centre | 124,000,000 | 20 | 243,270,800 | 20 |
| Dispensary | 124,000,000 | 20 | 243,270,800 | 20 |
| Community | 93,000,000 | 15 | 182,453,100 | 15 |
| **Total** | **620,000,000** | 100 | **1,216,354,000** | 100 |

Note: Note that in 2007/08 CCHP the term DMO is used instead of Municipal Medical Office of Health (MMOH) which is used in the 2006/07 CCHP and other Dar es Salaam Municipal Councils.

In the 2007/08 CCHP allocation of funds are shown by priority area. The priority areas include reproductive and child health, communicable diseases, non-communicable diseases, community health promotion and disease prevention and administration (Table 6.6). Administration took 86% of the total allocation in the referred period.

- *As mentioned earlier, due to arithmetic errors, these figures are not credible. The totals of the figures presented on page 10 (2007/08 CCHP) do not add up to the same figure vertically and horizontally.*

- *The 2005/06 CCHP shows allocation by priority area but only for the basket funds. The same arithmetic errors are observed on the figures presented on page 10.*

**Table 6.6: Allocation of Funds by Priority Areas**

| Sn. | Intervention | Basket Fund Budget* | % of the total | Total Budget | % of the total |
|---|---|---|---|---|---|
| 1. | Reproductive and child health | 35,000,000 | 7 | 138,393,709 | 5 |
| 2. | Communicable diseases control | 87,000,000 | 16 | 75,673,149 | 3 |
| 3. | Non-communicable diseases | 69,000,000 | 13 | 9,600,000 | 0.003 |
| 4. | Treatment and care of common diseases of local priority within the district | - | - | 45,990,000 | 2 |
| 5. | Health promotion and environmental health and sanitation | 133,670,000 | 25 | 118,139,999 | 4 |
| 6. | Strengthening organization structures and institutional capacities for improved health management at all levels | 203,728,000 | 39 | 2,476,403,027 | 86 |
| | **Total** | **528,398,000*** | **100** | **2,864,199,884** | **100** |

Source: CCHP (2005/06).
Note: *These allocations are for the basket fund only; not the total budget
** The total is not the same as the one reported above due to arithmetic errors.

It has not been possible to compare the budget allocations in the CCHPs with the actual expenditures as reported in the financial reports. This is due to the fact the figures presented on page 91 of the Annual Progress Report for the Council Comprehensive Health Plan for the period July 2006 to June 2007 are not clear on what they are portraying. The guidelines requires Councils to provide a health sector accounting return (recurrent) which shows a summary of funds in the current quarter, cumulative todate, and the budget year todate (CCHP Guidelines, p 80). Implication of this guideline is that if one is preparing annual summary, one has to show the funds in the last quarter (April to June), cumulative budget at that time, and the total yearly budget.

- *The Annual Progress Report for the Council Comprehensive Health Plan for the period July 2006 to June 2007 has reported summary A which is not clear what it*

*portrays; summary B that indicates the funds in April – June quarter; and another summary C named budget year todate/April to June 2007. It is not clear what budget C is although it differs from summary A and B.*

- *The annual implementation report should clearly show a summary of the last quarter allocation and the whole year, so that one can gauge the extent of budget execution.*

If we assume that summary C is the budget todate, then this differs from what is reported in the CCHP (TShs 4,049,979,104 versus TShs 3,289,842,464).

- *The implication is that the health interventions in the Council suffered because 19% of the budged was not raised.*

There is no evidence to suggest dumping of funds in the last quarter. If we assume summary A on page 91 of the Annual Implementation Plan is the summary for the April-June 2007 quarter, we see that TShs 925,727,444 were allocated for this quarter against a budget of TShs 4,049,979,104.

### 6.2.3 Performance Management

Assessment of the 2006/07 Annual Implementation Report shows that the Municipal organized activities by cost centre and per quarter. All except one activity that were under the MMOH's office were fully implemented in the April-June quarter. One important community activity was implemented only 25%; to conduct Expanded Program for Immunization (EPI) orientation to 80 health facility in-charges with Reproductive and Child Health services on the new technologies of vaccines refrigeration and new format of monthly EPI report forms. Activities at the hospital and Magomeni health center were fully implemented. Two activities at Sinza Health Centre were not fully achieved but they were initiated (provision of specialized supplies and equipment, for instance, ultra sound; procurement of an ambulance; and construction of a new incinerator). At dispensary level few activities were not implemented. These include purchasing of basic eye equipment; and improvement of diagnosis of malaria by procurement of requisite equipment.

The overall performance in the implementation of 2005/2006 CCHP was around 88%. There were areas where the performance was weak or below average. These include:

- Monitoring and supervisions of the private facilities. Only 70% of these were covered in the supervision missions.

- Capacity of health providers to provide health services. There is still congestion of patients in the public hospital and health centres versus the available health staff.

- Frequent outbreak of cholera disease.

- Quality analysis and management of the Health Management Information System (HMIS). There is inadequate data collection from both public and private health facilities. Further, some reports from the public facilities are not of the desired quality.

The same problems have been repeated in the 2007/08 CCHP which shows the overall performance in implementation of the 2006/07 CCHP to be around 85% (3% less when compared to the performance of the 2005/06 CCHP).

The 2007/08 CCHP has followed the new guidelines in preparing chapter five of the CCHP. The chapter shows the objectives, targets, and planned activities. This is an improvement from the earlier version of the chapter whereby planned interventions used indicated plus broad National Minimum Standards (NMS) outputs which in some cases could not be measured. For example, on page 31 of the 2006/07 CCHP one of the NMS output indicated is "management and coordination improved at all levels." It is difficult to measure this output as broad as it is.

- *It is essential that the achievement of the targets is followed through and reported consistently in the annual implementation reports*.

Chapter seven of each CCHP provide targets and monitoring performance indicators. These indicators are based on the National Minimum Standards (NMS). The Tables presented in chapter seven of both CCHPs do no provide remarks even where the target has not been reached or when the target has been surpassed. For example, the 2007/08 CCHP indicates that 32% of the deliveries took place at health facilities in 2004. However, in 2005/06 this declined to 17%. The expected output in 2006/7 and 2007/08 are mentioned to be 94% and 25% respectively. In the 2005/06 CCHP the achievement in 2003/04 and 2004/05 was mentioned to be 17% and 64% respectively.

- *Cleary, one can not see a trend in measurement of this indicator and one may wonder whether there is incremental improvement in the performance of this indicator. Further, the decline in performance of this indicator as shown in 2005/06 deserves explanation.*

### 6.2.4 Public Integrity Processes

Major issues in district specific public integrity processes are existence of mechanisms to prevent the misuse/abuse of public resources, and the capacity to respond to cases of misuse and/or abuse of public resources. It is worth noting that the CCHPs and annual implementation reports are tools that guide the planning, budgeting, and implementation processes and they do not reflect the mechanisms to oversee the use of resources. The Auditor and Controller General Report on financial statement can shade some light on public integrity processes as it points out the case of misuse of misappropriation of funds.

There are several audit issues raised in the Report of the Controller and Auditor General on the Financial Statement of Kinondoni Municipal Council for the financial year ended 30th June 2006. However, only two issues are picked here just to shade some light on public integrity processes. Full analysis of the reports of the Controller and Auditor General is presented in another report.

- An audit review of the implementation of the previous year's audit recommendations has revealed that the Council management has made progress in implementing audit recommendations, except for the four outstanding issues (Table 6.7).

- In the course of transaction of the audit carried out during the year under review, 55 audit queries were issued seeking remedial measures on various irregularities observed during the audit. However, as at the date of this report (end of June 2006) only 22 audit queries have been satisfactorily replied and closed leaving 33 not replied. In addition, one audit query No.14 relating to the period January-June, 2004 involving an amount of TShs 9,024,384 is still outstanding.

**Table 6.7: Status of Implementation of the Queries from the Auditor Report**

| Reference | Audit Recommendation | Status |
|---|---|---|
| 3.1 | (i) Efforts should be made to recover loans granted to Women and Youth amounting TShs 26,544,750<br>(ii) The Municipal Council should ensure recovery of TShs 68,924,957 from City Council | (i) A total of TShs 5,870,230 has been recovered leaving a balance of TShs 20,674,520 outstanding.<br>(ii) Not implemented, and the amount has not been disclosed in financial statements for 2005/06. |
| 3.6 | Outstanding Imprests totaling TShs 10,845,168. Clearance of the amount was called for. | Amount of TShs. 6,681,360 were verified to have been retired leaving a balance of TShs 4,163,808. |
| 3.7 | Efforts should be made to recover outstanding Debtors worth TShs 854,614,593. | A total amount of TShs 576,773,727 has been recovered leaving a balance of TShs 277,840,866. |
| 3.8 | Efforts should be made to clear Stale cheques worth TShs 72,552,185. | Stale cheques worth TShs 59,295,520 have been cleared leaving a balance of TShs 13,256,665. |
| | **Total value of Outstanding Issues** | **TShs 315,935,859** |

- *The district management has been urged to address the queries before the next audit. Further, district financial reports have to be freely available not only to the audit team but the whole public.*

### 6.2.5 Informed and Improved Planning

There is some evidence to suggest that there is improvement in planning in particular on chapter 5 of the CCHP where reporting of objectives, targets, and planned interventions is done as per new guideline. This chapter has clearly stipulated the targets to be achieved in the medium term (June 2010). The specific targets resonate around improved quality of care, workers performance and reduced HIV infections and maternal and child mortality.

- *The performance in these indicators has to be measured and reported in the 2008/09 financial and technical report.*

However, there are several indicators that show that there is no informed planning, that is, the current CCHP does not build on the last year's CCHP. This is evidenced by;

- The performance indicators presented on chapter seven where one can not see a clear trend over time;

- Failure to report PE and OC separately in the 2007/08 CCHP; and
- Failure to provide adequate data on funds actually received and in comparison to the funds allocated in the planning period.

➢ *It is imperative to build on previous CCHPs in order to gauge the achievements and challenges faced in the preceding year, and thus plan realistically.*

## 6.3 Major Conclusions and Issues of Concern

The following are major conclusions and issues of concern noted from the review.

***Major Conclusions***

1. There is substantial decrease in the nominal budget allocation in the two years in particular for the block grant which has decreased sharply in 2007/08 (more than 100% decrease).

2. The central government through the block grant (for OC and PE) was the main source of funds for the Municipal health activities in the 2006/07 budget. However, the block grant decreased substantially in 2007/08.

***Major Issues of Concern***

1. In the situation analysis chapter data are sourced from HMIS and national sources without necessary making a distinction. It is important to report the sources of the reported figures and whether the figures represent national picture or the district picture using the data generated from the HMIS.

2. There is gross error in arithmetic which makes some figures presented in the CCHP doubtful. See figures presented in Budget summary (pages 8-10). The total budget in 2007/08 is indicated to be 1,874,239,000 instead of 2,964,239,000. Another gross arithmetic error is noted on page 13 of 2007/08 CCHP whereby the subtotal of the budget from basket fund for priority area on strengthening organization structures and institutional capacities for improved health management at all levels is indicated to be **TShs 2,740,543,999** instead **of TShs 868,295,691**.The reported subtotal is more than the total basket grant (**TShs 1,216,354,000**). Several other arithmetic errors are reported as discussed in this subsection.

3. Going by these wrong figures, one would be startled by the substantial decrease in the budget compared to the budget allocations in the 2006/07 CCHP. However, even after correcting the figure, there is still a substantial decrease which deserves explanation.

4. The block grant decreased substantially in 2007/08. This deserves explanation. For example, what is the implication of decreasing the funds for PE? Is it true that the block grant funds were substantially decreased or there is an error in recording as noted throughout the analysis?

5. Separating PE from OC has not been done in the 2007/08 budget

6. Whereas other CCHPs such as those for Temeke and Ilala Municipalities reported the allocated resources in the previous years and make a comparison with the funds allocated in the planning periods, this has not been done satisfactorily for both reviewed Kinondoni CCHPs.

7. The balance brought down as unspent funds in the previous years are not indicated in the CCHPs. For consistency, this has to be included in the CCHPs when determining funds available for the planning year.

8. Information on allocation per cost centre for the whole budget was only available in the 2006/07 CCHP. It is imperative to report budgets per cost centre not only for the basket grant but also for the total budget. This will help to shade light on the burden of activities at different levels of health care.

9. The reviewed CCHPs do not provide the ceiling allowed per cost centre. In order to enhance transparency, we propose that CCHPs should show the ceiling allowed per cost centre and provide explanation whenever the allocations deviate form the allowed ceiling.

10. The Annual Progress Report for the Council Comprehensive Health Plan for the period July 2006 to June 2007 has reported summary A which is not clear what it portrays; summary B that indicates the funds in April – June quarter; and another summary C named budget year todate/April to June 2007. It is not clear what budget C is although it differs from summary A and B. Thus, the annual implementation report should clearly show a summary of the last quarter allocation and the whole year, so that one can gauge the extent of budget execution.
11. The 2007/08 has followed the new guidelines in preparing chapter five of the CCHP. The chapter shows the objectives, targets, and planned activities. It is essential that the

achievement of the targets is followed through and reported consistently in the annual implementation reports.

12. Chapter seven of each CCHP provide targets and monitoring performance indicators. However, one can not see a trend in measurement of these indicators and one may wonder whether there is incremental improvement in the performance of these indicators.

13. There are some audit queries that the district management has to address before the next audit. Further, district financial reports have to be freely available not only to the audit team but the whole public.

# 7.0 KIBAHA DISTRICT COUNCIL

## 7.1 Introduction

The Kibaha District Council is one of the seven councils making Coast Region. Others include Bagamoyo, Mafia, Kisarawe, Rufiji, Mkuranga and Kibaha Town Council. According to 2007 projected population census, the Council has a total population of about 65,288 inhabitants. The population is 49.97% males and 50.03% females. Table 7.1 shows the vital statistics for the district.

**Table 7.1: Vital Statistics**

| Sn. | Variable | Value |
|---|---|---|
| 1. | Total population | 65,288 |
| 2. | Population growth rate (%) | 3.4 |
| 3. | Births (2.6%) | 26/1000 |
| 4. | Children <1 year (2.6%) | 1,697 |
| 5. | Children <5 year (12.3%) | 8,030 |
| 6. | Women: 15-49 years (25.5%) | 16,648 |
| 7. | Maternal mortality | 7 deaths per year |
| 8. | Undefive morality | 36/1000 |

The mode of health service delivery in Kibaha District Council just like other councils is based on curative, preventive and promotive health care and rehabilitative services provided by government owned health facilities. These include hospitals, health centres and dispensaries.

In 2004, the top five diseases in the Municipal were found to be malaria, Acute Respiratory Infections (ARI), pneumonia, diarrhoea diseases and intestinal worms. In 2005, malaria, pneumonia, and diarrhoea infections remained on the list of the top five diseases plus anaemia, and HIV and AIDS/Pulmonary Tuberculosis (PTB). In 2006, the top five diseases in the District were found to be malaria, ARI, pneumonia, diarrhoea diseases and skin infection.

The 2007/08 CCHP was developed basing on the laid down priorities with focus on;

- Reducing under five and maternal mortality rate
- Combating the spread of HIV and AIDS, eye infection and dental carries

- Inadequate health facilities (availability of human, financial and materials resources for better delivery of health services).
- Poor waste water drainage at health facilities.

## 7.2 Analysis of CCHPs and Technical and Financial Reports

### 7.2.1 Planning and Resource Allocation

Analysis of CCHPs was done to gauge the available financial and non-financial resources for delivery of health services. Table 7.2 shows the trends in budgetary allocations from different sources for health services delivery in Kibaha District Council. There is notable increase in the nominal budget allocation in the three years. In nominal terms, the budget increased by 50% for both 2006/07 and 2007/06 periods. Improvement has been observed in reporting in particular with separating the block grant to OC and PE as noted in the 2007/08 CCHP. This means one can not know exactly what money from block grant was used for actual interventions. There is notable increase in the cost sharing funds. Although it declined by more than 50% in 2006/07, it increased substantially in the 2007/08 budget.

**Table 7.2: Funds from Various Sources (TShs)**

| Sn. | Source of Funds | 2005/06* | 2006/07 | 2007/08 |
|---|---|---|---|---|
| 1. | Community/Cost Sharing | 13,000,000 | 6,000,000 | 69,289,000 |
| 2. | MoH | 33,204,350 | 114,441,076 | 268,651,600 |
| 3. | Basket fund | 78,680,300 | 40,555,000 | 78,536,575 |
| 4. | Council Own Funds | 500,000 | 4,000,000 | 1,600,000 |
| 5. | Block grant for OC and PE | 273,359,988 | 361,287,165 | 665,211,896 |
| | *Block grant for PE/Salary* | - | - | *562,211,897* |
| | *Block grant for OC* | - | - | *103,000,000* |
| 6. | Other Sources ** | 349,213,972 | 604,396,390 | 630,644,941 |
| | **Grand Total** | **747,958,610** | **1,130,679,631** | **1,713,934,012** |

* In 2005/06 some block grant funds were for the Kibaha Town Council (KTC)

** 2007/08 (Plan, MDM, UNICEF, Marie Stopes, Path, Columbia, and TASAF); 2006/07 (Plan, MDM, UNICEF, TACAIDS, and TASAF); 2005/2006 (Plan, MDM, and UNICEF).

Figure 7.1 compares the nominal increase versus real increase in allocations for the past three years. As the figure portray, in both nominal and real terms, there is a notable increase in the budget from 2005/06 to 2007/08. However, the difference between the nominal and real budget is high in 2007/08 period due to high Consumer Price Index.

**Figure 7.1: Trend in Nominal and Real Budget Allocation**

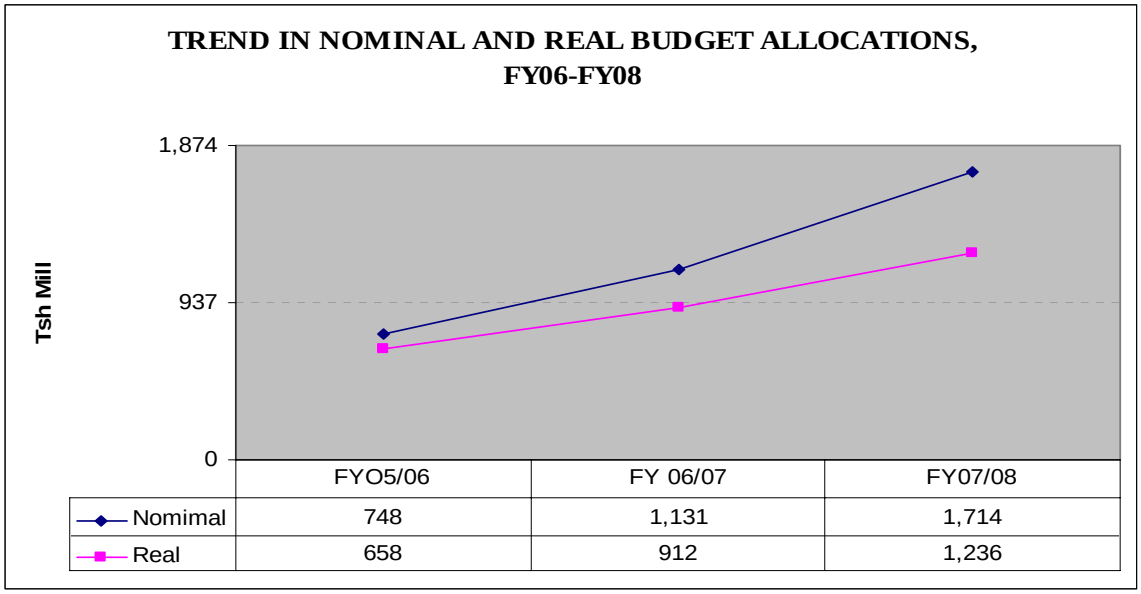



Table 7.3 shows the percent contribution of each type of funding source. The major source of funding for the 2005/06 and 2006/07 is the other sources (see notes under Table 7.2). In 2007/08 budget the other source rank the second after the block grant. The Council own fund is the least source of fund for the district.

**Table 7.3: Percent Contribution of Each Type of Funding Source**

| Source of Funds | 2005/06 | % of total | 2006/07 | % of total | 2007/08 | % of total |
|---|---|---|---|---|---|---|
| Community/Cost Sharing | 13,000,000 | 1.7 | 6,000,000 | 0.5 | 69,289,000 | 4.0 |
| MoH | 33,204,350 | 4.4 | 114,441,076 | 10.1 | 268,651,600 | 15.7 |
| Basket fund | 78,680,300 | 10.5 | 40,555,000 | 3.6 | 78,536,575 | 4.6 |
| Council Own Funds | 500,000 | 0.1 | 4,000,000 | 0.4 | 1,600,000 | 0.1 |
| Block grant | 273,359,988 | 36.5 | 361,287,165 | 32.0 | 665,211,896 | 38.8 |
| Other Sources | 349,213,972 | 46.7 | 604,396,390 | 53.5 | 630,644,941 | 36.8 |
| **Grand Total** | **747,958,610** | **100.0** | **1,130,679,631** | **100.0** | **1,713,934,012** | **100.0** |

The following are issues arising from the analysis:

- *The notable increase in the cost sharing/community fund over time is a positive trend which could be taken to mean that health users are starting to accept that health financing is the responsibility of both the state and citizens.*

- *There is improvement in reporting for block grant that is, separating PE from OC in 2007/08. This is necessary as we need to know exactly what money from block grant was used for actual interventions*

- *The other sources and central government through the block grant (for OC and PE) remains the main source of funds for the Council health interventions.*

- *Errors in reporting; the total under the main budget summary of 2005/06 CCHP is not correct (page 13), but subsequent CCHPs have improved with accurate summations. Summations errors are also observed on page (i) of the executive summary of the Annual Progress report (2006/07). The total payments to different cost centres is reported to be TShs 403,771,171 but the correct figure is TShs 380,328,764*

- *The balance brought down as unspent funds in the previous years are not indicated in the CCHPs. For consistency, this has to be included in the CCHPs when determining funds available for the planning year.*

### 7.2.2 Effectiveness and Efficiency of Expenditure Management

Comparisons were to be made between the budgetary allocations as reported in the CCHPs and the actual received funds. However, the Kibaha Council CCHPs did not indicate the actual collected funds (see others Councils for instance Ilala Municipal Council which reported the budgetary allocations and the actual funds collected—Table 4.4)

- *Thus, it is imperative to report in each subsequent CCHP the funds collected in the previous year and the allocations for the planning period (budget for the current year). This will give a picture over time of what is budgeted and what is actually collected.*

Table 7.4 shows trends in allocation of Basket Fund per cost centre for 2006/07 and 2007/08 (disaggregated figures are not available in the 2005/06 CCHP)[11]. The Table shows that except for the hospital/DDH and rural health centre, the same proportion of the funds have been allocated to the cost centres for the two years. However, the CCHP does not provide the ceiling allowed per cost centre.

[11] Note that on page 14 of the 2005/06 CCHP there is a table providing a summary of allocations per cot centre but this is for July 2004 to June 2005, not July 2005 to June 2006.

- *In the summarized District Health Accounts, the guidelines on the ceiling for the basket fund are presented. In order to enhance transparency, we propose that CCHPs provide explanation whenever the allocations deviate from the allowed ceiling as is the case with allocations in Table 7.4.*

- *CHMT is a cost centre which is not funded by the basket fund.*

- *Further, the CCHPs do not provide total budget per cost centre which makes it hard to know how much is allocated to a cost centre unless one does the additions.*

- *The three CCHPs show the allocations to allowances and fuel to be within the allocated ceiling.*

**Table 7.4: Trends in Allocation of Basket Fund per Cost Centre**

| Cost Centre | 2006/07 | % of total | 2007/08 | % of total | % Share as per guideline |
|---|---|---|---|---|---|
| Hosp/DDH | 12,166,500 | 30 | 19,634,200 | 25 | 35 |
| Rural Health Centre | 8,111,000 | 20 | 19,634,125 | 25 | 15 |
| District Dispensary | 8,111,000 | 20 | 15,707,300 | 20 | 15 |
| Community | 4,055,500 | 10 | 7,853,650 | 10 | 10 |
| DMOs office | 8,111,000 | 20 | 15,707,300 | 20 | - |
| CHMT/Health Boards | - | - | | | 10 |
| Unallocated flexibility | - | - | | | 5-10 |
| **Total** | **40,555,000** | **100** | **78,536,575** | **100** | **-** |

In the action plan sections of the CCHPs, details on interventions and cost per cost centres is include. However, there is no summary table indicating allocations per cost centre for the whole budget. The annual progress report (2006/07) shows the expenditures per cost centre (Table 7.5).

- *It is noted that the total budget indicated in the 2006/07 CCHP is significantly high than the total expenditures as reported in the annual report. The funds reported in the annual report portray only 36% of the expected amount. The implication is that the implementation of the council health interventions suffered due to under funding.*

- *It is imperative to report budgets per cost centre not only for the basket grant but also for the total budget in the CCHPs. This will help to shade light on the burden of activities at different levels of health care.*

**Table 7.5: Expenditure per Cost Centre**

| Sn. | Cost Centre | Amount (TShs) |
|---|---|---|
| 1. | Council Health Department | 80,493,323 |
| 2. | Council/CDH/Hospital | 11,665,500 |
| 3. | Urban Health Centre | 0 |
| 4. | Rural Health Centre | 90,081,464 |
| 5. | Dispensary | 198,088,477 |
| 6. | Community Initiative | 17,608,155 |
| | **Total payments** | **380,328,764** |

Source: Annual Progress Report (2006/07) p (i)

In the three CCHPs reviewed, allocated funds are shown by priority area (Table 7.6). The priority areas include reproductive and child health, communicable diseases, non-communicable diseases, water and hygiene, and administration and salaries. Administration took a big chunk of funds ranging from 48% to 73% of the total allocation in the review period. It is worth noting however that salaries, procurement of medical supplies and renovation of infrastructure are indicated under the administration budget and this may be explaining why the observed huge share of the total budget.

- *No robust conclusions can be made from the analysis by allocations by priority area since there is no fixed formula for allocations per priority areas.*
- *However, it is imperative to continue providing the information on allocations per priority areas in order to gauge the extent at which the budget allocations reflect health priorities in the Council, and whether there improvements in spending for priority interventions versus administration.*

**Table 7.6: Spending by Priority Area**

| Priority Area | 2005/06* | % of the total | 2006/07 | % of the total | 2007/08 | % of the total |
|---|---|---|---|---|---|---|
| Reproductive health | 45,242,076 | 7 | 261,991,856 | 23 | 190,418,055 | 11 |
| Communicable diseases | 265,235,078 | 42 | 233,454,255 | 21 | 262,158,647 | 15 |
| Non communicable diseases | 518,320 | 0.1 | 1,000,000 | 0.1 | 2,000,000 | 0.1 |
| Water/hygiene | 17,273,548 | 3 | 44,444,500 | 4 | 18,726,800 | 1% |
| Administration and salaries | 301,973,573 | 48 | 589,789,020 | 52 | 1,246,741,361 | 73 |
| **Total** | **630,242,595** | **100** | **1,130,679,631** | **100** | **1,713,934,012** | **100** |

* Note that due to arithmetic errors, the total for 2005/06 is nit the same as the one presented in Table 7.3.

### 7.2.3 Performance Management

Assessment of the annual implementation report for the year 2006/07 shows that almost all activities were fully implemented except few activities as shown in Table 6.7. In only one activity the performance was surpassed; the target was to pay leave travel allowance to four staff but five were paid.

**Table 7.7: Activities not Achieved, 2006/07**

| Level of Cost Centre | Planned Activities | Achievement (%) | Comments |
|---|---|---|---|
| CHMT | Conducting supportive supervision to 19 health facilities (64 routes) | 81 | Delayed disbursement of funds |
| CHMT | Computer training to 3 heath workers | 0 | Failure of donor to release funds |
| CHMT | Training of 13 CHMT and co-opted members on cascade | 0 | Failure of donor to release funds |
| Dispensary | Conducting training to 26 health worker on Community Based Pregnancy Monitoring (CBPM). | 0 | PLAN International delayed disbursement of funds; carried forward to year 2007/08. |
| Dispensary | Training on management of opportunistic infections and ARVs | 0 | PLAN International delayed disbursement of funds; carried forward to year 2007/08. |
| Dispensary | Expansion of Soga dispensary | 0 | Delayed disbursement of funds by TASAF |
| Dispensary | Finishing of staff quarter at Kwala dispensary | 0 | Delayed disbursement of development funds |

The activities that were not implemented were attributed mostly to delay of funds and failure of the donors to release funds. Delay of release of funds is reflected in the closing balance at the end of the period (30.06.2007) was TShs 155,072,929; this means that this sum was not available on time for implementation of the planned activities.

- *The result that is intriguing is the fact that almost all activities were implemented fully (100%) despite the fact that only 36% of the funds were made available in the 2006/07 period. This leaves one with question mark on whether;*
    a. *The information presented on the page (i) of executive summary of the annual progress report (2006/07) is correct (given other arithmetic errors reported in above).*
    b. *The information presented in the executive summary only reflects the last quarter expenditures.*

Another indicator of performance management is achievement made with regard to District objectives. Table 6.8 shows the achievement of the objectives as stipulated in the 2005/06 CCHPs (for the 2006/07 and 2007/08 information see the executive summary of respective CCHPs).

**Table 7.8: Achievement of the Objectives of the CCHPs**

| Sn. | 2004/2005 Objectives | Achievement (2005) |
|---|---|---|
| 1. | To reduce high prevalence of malaria from 52.2%-51.2% by June 2005 | Reduced by 15.8% |
| 2. | To reduce the prevalence of pneumonia from 9.7%-8.5% by June 2005 | Reduced by 2.5% |
| 3. | To reduce the prevalence of diarrhea from 5.4% to 4.4% by June 2005 | Reduced by 0.9% |
| 4. | To reduce the prevalence of anemia from 4.1%-3.8% by June 2005 | - |
| 5. | To reduce the prevalence of intestinal worms from 4.6%-4.3% by June 2005 | Reduced by 0.3% |
| 6. | To reduce high prevalence of infant mortality rate from 89/1000 to 85/1000 by June 2005 | Reduced to 65/1000 |
| 7. | To reduce high prevalence of maternal mortality rate from 34 deaths to 32 deaths by June 2005 | Reduced by 41% |
| 8. | To reduce high prevalence of underfive mortality rate from 97/1000 to 95/1000 by June 2005 | Reduced by 34-29 deaths |
| 9. | To reduce high prevalence of HIV from 8.2% to 7.2% by June 2005 | - |
| 10. | To reduce high prevalence of TB from 520 to 480 case by June 2005 | Reduced to 335 |
| 11. | To reduce high prevalence of eye diseases from 3.6% to 3.0% by June 2005 | Reduced by 1% |
| 12. | To reduce high prevalence of dental caries from 1,446 to 1,200 cases by June 2005 | Reduced 80/1000 |
| 13. | Improve the existing health delivery system through construction of health facilities from the existing 17 health facilities to 21 health facilities by June 2005 | 4 facilities constructed |

The same objective have been presented in the 2006/2007 and 2007/2008 CCHPs. Each CCHP has detailed the objectives and achievements.

- *Analysis of these objectives reflects the intentions of the district to deal with the major health problems in the district.*
- *Further, the CCHPs are incremental in the sense that the objectives of the subsequent years are based on the achievement made in the preceding year's objective.*

- *However, there is inconsistency on the achieved level of objectives. For instance, the CCHP 2005/06 showed the intention of reducing the high prevalence of malaria from 52.2%-51.2% by June 2005. Further, the 2006/07 CCHP reported the intention to reduce high prevalence of malaria from 47% to 44% but the 2007/08 CCHP pointed out the intention of reducing malaria from 51.2% to 49.29% the level that is very close to the 2005/06. The interpretation could be that the statistics in the 2006/06 CCHP are not credible and there have not been systematic measure of the percent of malaria cases.*

- *It is also noted that the objectives and achievements are only presented in the executive summary and not in the text. A thorough presentation of these in the core text in chapter five is called for.*

- *The same unit of analysis should be used (see Table 6.8 items 7 and 12).*

The 2007/08 CCHP innovative in the sense that it shows the expenditure shares per interventions and whether the expenditures are commeasure with the budget of the intervention (this has not been the case with other CCHPs reviewed).[12] The expenditure on the Integrated Management of Childhood Illnesses (IMCI), malaria control and HIV/STI control, and Tuberculoses (TB) Direct Observed Therapy (DOTS) is less than the burden of the disease. Expenditures on SMI, EPI, and injuries are proportionate to the burden of disease. However, expenditure on "other diseases" is very high compared to the burden of the disease (more than 20% versus 5% respectively).

- *Thus, there is a need to describe what is in the "others diseases" in order to unravel what makes the expenditure on this item very high.*

The 2007/08 CCHP also shows the total health system support shares. The capital funds accounts for 43% of all funds followed by personnel emoluments (29%) and direct health services (24%).

### 7.2.4 Public Integrity Processes

Major issues in district specific public integrity processes are existence of mechanisms to prevent the misuse/abuse of public resources, and the capacity to respond to cases of misuse and/or abuse of public resources. It is worth noting that the CCHPs and annual implementation reports are tools that guide the planning, budgeting, and implementation processes and they do not reflect the mechanisms to oversee the use of resources. The

[12] See the last pages of the 2007/08 CCHP (no page numbers are indicated).

Auditor and Controller General Report on financial statement can shade some light on public integrity processes as it points out the case of misuse of misappropriation of funds.

Several issues have been raised in the Report of the Controller and Auditor General on the Financial Statement of Kibaha District Council for the financial year ended 30th June 2006. These include:

(i) Weak procumbent management
(ii) Weak fixed asset register
(iii) Stores not accounted for TShs 50,989,000
(iv) Stores not supported by issue vouchers for TShs 17,238,950
(v) Doubtful issues of store items for TShs 45,606,900
(vi) Improperly vouchered expenditure for TShs 31,094,459
(vii) Irregular questionable payments for TShs 82,495,986
(viii) Understated expenditure for TShs 15,570,523
(ix) Outstanding debtors amounting to TShs 5,468,274
(x) Current liabilities of TShs 123,769,402
(xi) Outstanding items of Bank Reconciliation Statements amounting to TShs 103,141,508.

- *Despite these queries, Auditor commended the Council for dealing satisfactorily with the queries raised in the previous years audit reports.*

One notable feature of the Kibaha DC CCHPs is indication of the action plan and who is responsible for implementation of each activity.

- *Presentation of an action plan and individual responsible for each action is one step towards accountability.*

### 7.2.5 Informed and Improved Planning

There is evidence to suggest that there is some consequent informed planning, that is, incremental planning whereby last year's Plan inform the subsequent Plan. This is shown by the reflection of the last year's targets and achievements in the current year's CCHP and builds on that (although there are some inconsistencies as reported above).

- *More could be done in this area by making sure that credible HMIS data are obtained to measure the achievement of the targets and establish trend over time.*

There is some evidence to suggest that the planning process has improved over time. This is in particular with adopting the current CCHP guidelines. However, more needs to be done. Chapter five shows the objectives, targets, and planned interventions. But some of the targets are not quantified and thus not measurable.

- *For example, page 15 of the 2007/08 CCHP indicates one of the targets to be "to supply health facilities with necessary equipments, drugs, and vaccines by June 2008." This could be an objective but not a target because targets have to be quantified.*

As mentioned above, improvement has been observed in reporting in particular with separating the block grant to OC and PE as noted in the 2007/08 CCHP. This means one can not know exactly what money from block grant was used for actual interventions.

## 7.3 Major Conclusions and Issues of Concern

***Major Conclusions***

1. There is notable increase in the nominal budget allocation in the three years reviewed.

2. Improvement has been observed in reporting in particular with separating the block grant to OC and PE as noted in the 2007/08 CCHP. This means one can not know exactly what money from block grant was used for actual interventions.

3. There is noteworthy increase in the cost sharing funds. Although it declined by more than 50% in 2006/07, it increased substantially in the 2007/08 budget. The notable increase in the cost sharing/community fund over time is a positive trend which could be taken to mean that health users are starting to accept that health financing is the responsibility of both the state and citizens.

4. The other sources and central government through the block grant (for OC and PE) remains the main source of funds for the Council health interventions

5. One notable feature of the Kibaha DC CCHPs is indication of the action plan and who is responsible for implementation of each activity. Presentation of an action plan and individual responsible for each action is one step towards accountability.

***Major Issues of Concern***

1. The other sources of funds contributed the highest share of the budget in the 2005/06 and 2006/07period but the government through the block grant (for OC and PE) was the main source of funds for the Council health interventions in 2007/08. This reversal is called for (having the bigger share coming from the government) even in the subsequent years for sustainability of health related interventions.

2. There were several arithmetic errors in reporting. For instance, the total under the main budget summary of 2005/06 CCHP is not correct (page 13). Summations errors are also observed on page (i) of the executive summary of the Annual Progress report (2006/07). The total payments to different cost centres is reported to be TShs 403,771,171 but the correct figure is TShs 380,328,764

3. The balance brought down as unspent funds in the previous years are not indicated in the CCHPs. For consistency, this has to be included in the CCHPs when determining funds available for the planning year.

4. The reviewed CCHPs did not report the actual collected funds versus funds for the planning period. It is important to report in each subsequent CCHP the funds collected in the previous year and the allocations for the planning period (budget for the current year). This will give a picture over time of what is budgeted and what is actually collected.

5. In order to enhance transparency, we propose that CCHPs provide explanation whenever the allocations deviate from the allowed ceiling as is the case with allocations in Table 6.4.

6. The reviewed CCHPs did not provide a summary table of total budget per cost centre which makes it hard to know how much is allocated to a cost centre unless one does the additions.

7. It is noted that the total budget indicated in the 2006/07 CCHP is significantly high than the total expenditures as reported in the annual report. The funds reported in the annual report portray only 36% of the expected amount. The implication is that the implementation of the council health interventions suffered due to under funding.

8. It is of the essence to report budgets per cost centre not only for the basket grant but also for the total budget in the CCHPs. This will help to shade light on the burden of activities at different levels of health care.

9. It is also important to continue providing the information on allocations per priority areas in order to gauge the extent at which the budget allocations reflect health priorities in the Council, and whether there improvements in spending for priority interventions versus administration.

10. It is noted that the total budget indicated in the 2006/07 CCHP is significantly high than the total expenditures as reported in the annual report. The funds reported in the annual report portray only 36% of the expected amount. The implication would be that the implementation of the council health interventions suffered due to under funding. However, almost all activities were implemented fully (100%) despite these obvious under funding. This leaves one with question mark on whether;
    a. The information presented on the page (i) of executive summary of the annual progress report (2006/07) is correct (given other arithmetic errors reported).
    b. The information presented in the executive summary only reflects the last quarter expenditures.

11. It is noted further that the CCHPs are incremental in the sense that the objectives of the subsequent years are based on the achievement made in the preceding year's objective. However, there is inconsistency on the achieved level of objectives. It is also noted that the objectives and achievements are only presented in the executive summary and not in the text. A thorough presentation of these in the core text in particular in chapter five is called for.

12. The 2007/08 CCHP innovative in the sense that it shows the expenditure shares per interventions and whether the expenditures are commeasure with the burden of the intervention. Expenditure on "other diseases" is very high compared to the burden of the disease (more than 20% versus 5% respectively). Thus, there is a need of describing what is in the "others diseases" in order to unravel what makes the expenditure on this item very high.

13. Several queries were raised by the Auditor and Controller General which need to be addressed. Despite these queries, Auditor commended the Council for dealing satisfactorily with the queries raised in the previous years audit reports.

# 8.0 MAJOR GENERAL CONCUSSIONS AND RECOMMENDATIONS

Several conclusions and major issues of concern have been raised per Council as presented in the preceding chapters. This chapter lifts issues that are of general nature and which cut across the majority of the reviewed Councils.

1. Except for Kinondoni, there is an increase in nominal budget allocations in the three years.

2. In all the CCHPs the syndrome of copying and pasting without necessarily updating was evident as indicated by the examples provided in the text. This was much so in Ilala CCHPs.

3. Except for Kibaha DC and in 2005/06 and 2006/07 where "other sources" were mentioned to be the main source of funds, the central government through the block grant for OC and PE remained the main source of funds for three Dar es Salaam Municipal Councils and for the period 2007/08 for the Kibaha DC.

4. There is a notable increase in the PE in particular for Ilala and Temeke MC which is not commensurate with the trend in OC allocation. The implication is that no improvement is seen from the central government for the OC allocations which affects implementation of priority interventions.

5. There was increase in the cost sharing fund over time for the four Councils. This is a positive trend which could be taken to mean that health users are starting to accept that health financing is the responsibility of both the state and citizens.

6. The funds from Temeke Municipal Council have remained low and constant in the three years. This can be interpreted as lack of the Municipal policy makers and planners to make health a priority area of spending in the Municipality. Funds in other Councils have shown an increasing trend over time.

7. There were gross arithmetic errors in the CCHPs of all the districts, and even the annual implementation reports. The worse cases were cited in Kinondoni MC. What this could mean is that the budget officers are compiling the budgets and reports manually. The need of training in the use of Excel Software is of essence. Further, cross checking of figures presented in different sources is called for.

8. Other sources of funds are not defined in several CCHPs. A footnote explaining what these other sources of funds are is called for.

9. Whereas other CCHPs such as those for Temeke and Ilala Municipalities reported the allocated resources in the previous years and make a comparison with the funds allocated in the planning period, this has not been done satisfactorily for Kinondoni MC and Kibaha DC CCHPs.

10. One notable feature of the Kibaha DC CCHPs is indication of the action plan and who is responsible for implementation of each activity. Presentation of an action plan and individual responsible for each action is one step towards accountability. This is a best practice that should be emulated by other Councils.

11. The balance brought down as unspent funds in the previous years are not indicated in the CCHPs. For consistency, this has to be included in the CCHPs when determining funds available for the planning year.

12. In order to enhance transparency, we propose that CCHPs should show the ceiling allowed per cost centre and provide explanation whenever the allocations deviate from the allowed ceiling.

13. Some CCHPs have shown allocated funds per priority area; at least for the basket fund. This kind of presentation has however not been done in all CCHPs. It is imperative to provide the information on allocations per priority areas in order to gauge the extent at which the budget allocations reflect health priorities in the Council, and whether there are improvements in spending for priority interventions versus administration.

14. Except for Kibaha DC, there is no evidence that the subsequent CCHPs build on the previous ones. The Kibaha DC CCHPs show the objective of the preceding year, what has been achieved and the current year plan builds on the observed achievements. It is imperative to build on previous in order to gauge the achievements and challenges faced in the preceding year, and thus plan realistically.

15. Reporting for NMS indicators is provided in all the CCHPs. However, no follow up of Council specific indicators is shown except for Kibaha DC. The need to follow up and report on the Council specific indicators as generated from the HMIS is of the essence. This is because these indicators are localized and it is important to

achieve them for increased efficiency and effectiveness in the performance of specific Council.

16. For all the reviewed Councils, there are some audit queries that the Council management has to address before the next audit.

17. The 2007/08 Kibaha DC CCHP is innovative in the sense that it shows the expenditure shares per interventions and whether the expenditures are commeasure with the burden of the intervention/disease. Although it is not clear on how the figures are arrived at, this is a best practise that shows whether the expenditures are commensurate with the burden of diseases.

18. Although in the CCHPs and annual implementation report CHMT meetings are reported as one activity, it is not clear in which document one can get the resolutions of these meeting and in particular with measures taken against fraudulent behaviours in financial management. Although it is not stipulated in the guidelines that these should be reported in the financial and technical reports, we propose for a sub-section in the technical and financial report on measures taken against such fraudulent behaviours.

19. All CCHPs have not provided the detailed main budget summary as depicted in Annex 2.1 page 67 of the guide. The 2008/09 and subsequent CCHPs should follow the guidelines as reviewed in 2007.

20. The availability of a Council Strategic Plan is only indicated for Ilala and Temeke MCs. Drafting Council Strategic Plans is important as they provide medium term objectives, targets and strategies that are then translated into short term in the CCHPs.

21. Evidence from Temeke MC, Ilala MC and Kibaha DC show that some activities have not been implemented due to delay of funds and dumping of funds in the last quarter.