

Operational challenges of engaging development partners in district health planning in Tanzania

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Abstract

Background: Development assistance for health represents an important source of health financing in many low and middle-income countries. However, there are few accounts on how priorities funded through Development assistance for health are integrated with district health priorities. This study aimed at understanding the operational challenges of engaging development partners in district health planning in Tanzania

Methods: This explanatory mixed methods study was conducted in Kinondoni and Bahi districts. A structured checklist to 35 participants collected quantitative data whereas a semi-structured guide collected qualitative from 20 key informants (the council health planning team members and the development partners) to obtain information related to engagement of development partners in the planning processes and subsequent implementation of the district plan. We used descriptive analysis for quantitative data and thematic analysis for qualitative data

Results: Majority (86%) of the development partners delivering aid in the studied districts were Non Governmental Organizations. We found high engagement of Development partners (DPs) (87.5%) in Bahi district and very low in Kinondoni district (37.5%). Guidance on district priorities to be included in Development partner's plans as part of the Comprehensive Council Health Plan (CCHP) was given to 36% of the Development partners. Submission of written plans to be integrated in the District plans was done by only 56% of Development partners, with majority (77.7%) from Kinondoni district not submitting their plans. Only 8% of the submitted plans appeared in the final District plan document. Qualitative findings reported operational challenges to engagements such as differences in planning cycles between the government and donors, uncertainties in funding from the prime donors, lack of transparency, limited skills of district planning teams, technical practicalities on planning tools and processes, inadequate knowledge on planning guidelines among DPs and poor donor coordination at the district level.

Conclusions: We found low engagement of Development partners in planning. To be resolved are operational challenges related to differences in planning cycles, articulations and communication of local priorities, donor coordination, and technical skills on planning and stakeholder engagement.

Background

As Low and Middle-Income Countries (LMIC) strive to strengthen their health systems, considerable efforts should be directed towards strengthening the district health system (DHS). District health system defined as a decentralized block of the national health system serves the majority of the population and is a means of achieving equitable, responsive and people centred health system (1). Provision of comprehensive primary health care services to the population as a core function of the DHS, can be achieved if the DHS is equipped in priority setting and planning on the use of the available scarce resources (2)(3). While laying down the DHS concept, the Harare declaration in 1987 put emphasis on the district planning process as one of the core activities of the DHS(4). Planning using the bottom up approach that ensures participation of a range of actors with a stake on provision of health services in the district health system is a desirable means of reaching the primary health care (PHC) goals and hence paving the way to universal health coverage (UHC)(2)(5). The participation of state and non-state actors such as development partners, the civil society, private for profit entities and the general public in planning the district health services is a stride forward for provision of equitable, comprehensive, quality and people centred health services(3).

Involving a range of relevant multiple stakeholders in the district planning can increase legitimacy, credibility, transparency and ownership of the DHS plan. Moreover, it can facilitate uptake of the interventions as awareness and mutual trust of the players is maximized through the participatory planning approach.

The relevance of participatory planning using a range of stakeholders is highlighted in existing evidence and has been examined in both in HIC and LMIC (6) across a range of health care services (7)(8). Among the relevant stakeholders in the DHS planning process are the development partners.

Development assistance for health (DAH) in the form of aid has been an important source of health financing in many LMIC(9). Of recent, the traditional approach of providing aid to "poor" countries by a handful bilateral or multilateral agencies has been

replaced by a more complex way of providing aid to countries with different levels of development and with new players in development assistance, that apart from bilateral and multilateral agencies, include also international Non-governmental organizations (NGOs), foundations, global alliances, consortia, philanthropies, initiatives and private corporations(10)(9). That means the number of development partners with a stake with district health services has been increasing and diversified.

Although declining in Tanzania, Development Assistance for Health (DAH) in form of aid, including concessional loans, still provides more than 10 percent of the Government budget and a disproportionate share of the financing for development and investment(11)(12).DAH is provided by the Development partners Group (DPG) which comprises of 17 bilateral and 5 multilateral agencies (counted as one).In 1999, the health sector in Tanzania entered into a Sector-Wide Approach (SWAP in order to improve efficiency in the use of domestic funds and externally sourced development assistance by integrating the funds into a joint sectoral framework(13). SWAP in the health sector was developed in response to widespread dissatisfaction with fragmented donor-sponsored projects and prescriptive adjustment lending (14). It was intended to provide a more coherent way to articulate and manage government-led sectorial policies and expenditure frameworks and build local institutional capacity as well as offer a means to more effective relationship between government and donor agencies (15). DAH is implemented in the form of budget support, Basket funds and projects.

There is scanty information on the involvement of development partners in the district health planning in Tanzania (16). In particular, when the form of aid is through basket fund support or a vertical project, participation of the development partners in the planning process at the local level (in this case the district) where such projects are implemented is important. Participation of the DPs could be direct or through the subcontracted (implementing) partners. The District Comprehensive Council Health Plans (CCHP) planning guidelines stipulates the role of different stakeholders in the planning process and therefore mandates the District Medical officer (chairperson of the planning team) to engage all the stakeholders in the planning process by also making sure that all health stakeholders plans are incorporated in the CCHP by using the planning and reporting tool (planrep) (17). Henceforth, the Council Health Management Team (CHMT) is charged with the responsibilities of planning, implementing, monitoring and evaluating health services delivery. In order to fulfil this task successfully, the teams are required to work together and involve different stakeholders at all stages (planning, budgeting and implementing) of their work.

The aim of the current study was to examine the engagement of development partners, specifically the development partners in the district health planning in Tanzania. Specifically we aimed to 1) identify the development partners involved in the CCHP planning process and how they are engaged 2) determine their perceptions and awareness of the CCHP planning process and 3) identify operational challenges affecting the engagement of the development partners in the CCHP planning process

Methods

Study settings

This study was conducted in Bahi and Kinondoni districts of Tanzania Mainland between November and December 2015. Kinondoni is an urban district (Municipality) in Dar es Salaam Region, the business capital of Tanzania Mainland. It has a total area of 321 square kilometres and a population of about 1,134,211 peoples. Bahi is a rural district among the 7 Districts of Dodoma Region, which is about 50 kilometres from Dodoma town and 500 kilometres from Dar es Salaam. The study was conducted in both urban and rural districts for the purpose of comparing urban and rural districts in the CCHP.

Study design

This was a mixed methods case study employing both qualitative and quantitative approaches. Taking a pragmatic stance, the mixed methods approach was to capture information related to development partner engagement in district planning process from multiple perspectives and provide an in-depth understanding of the process in the natural context. This study was explanatory in nature and started with the quantitative approach and was followed by qualitative interview for selected cases to give details on the observations obtained in the quantitative strand. The quantitative strand of the study involved the following activities; i) mapping of the development partners and their activities in each district, ii) assessment of the level of engagement of the DPs and district planning teams in the planning process iii) determining perceptions and awareness of the CCHP

planning process. The qualitative part mainly was used to describe how the DPs were engaged in the district health planning processes and understand the challenges of the process as described by the participants.

Study Sample And Sampling Procedures

Quantitative sample

In this component, the study population included the Development partners here defined as organisation /agency engaging with health development assistance at the local government (district) level, it includes multilateral and bilateral district projects, and NGOs (international, national, and Regional) operating in the particular district. Note that there is no universal definition of Development Partner and for the Ministry of Health, Community Development, Gender, elderly and Children (MOHCDGEC) in Tanzania Development Partners represents a group of 17 international institutions/organisations engaging with health developmental assistance and health sector dialogue through SWAP. The study population also included District health planning team and the Regional health management team. A list of 35 DPs operating in the study area was obtained from district offices. A simple stratified sampling was used to categorize the DPs according to the aims of the study. A sample size of 16 DPs (8 from each district) was selected Out of 35 DPs to participate in the quantitative survey. In order to understand the differences in terms of partner involvement in rural compared to urban districts and their actual involvement, we stratified the partners' in terms of their districts, their type and status of plan submission..

Qualitative sample

We purposively selected 20 key informants to participate in the in-depth interview. The selected participants represented the DPs (n = 14) and members of the planning team (n = 6).

Data Collection Tools And Procedures

Both primary and secondary data collection methods were used to obtain sufficient and realistic information for the study. Data collection tools were pretested before actual data collection. Trained research assistants collected the data in direct supervision by the first author.

Collection Of Quantitative Data

We used the following tools to collect quantitative data; i) A mapping checklist ii) A document review checklist and iii) a survey questionnaire.

We used a structured checklist to map the DPs in the district. The checklist collected information related to Development Partner name, type, area of support, duration of operation in the district, and their physical address.

A document review checklist was used to collect information from the 2014/15 CCHP documents, Partner plans, and minutes of the coordination meetings in the district.

A structured questionnaire was used to collect information from the participants. The survey mainly focused on understanding the integration between partner plans and district health plan and also partner participation in the process of developing the district CCHP

Collection Of Qualitative Data

Qualitative data were collected using a semi structured in-depth interview guide. We collected data from 20 key informants representing the 14 organisations and 6 participants from the district planning team members.

Data analysis

Guided by the research objectives, the collected data were analysed using descriptive statistical approaches and a thematic analysis to obtain quantitative and qualitative findings respectively.

Quantitative Data Analysis

Data from the questionnaire were analysed descriptively to generate frequencies percentages and means on the key variables of the study namely; 1) participation in comprehensive council health plan, measured as scores and categorized into Full participation, partial participation and no (zero) participation 2) presence of Memorandum of understating between the DP and the district, DP, 3) submission of DPs activities in writing for inclusion in CCHP, 4) Pre planning meeting, feedback on finalization of CCHP and number of DP participating in quarterly CCHP monitoring meeting. We were assisted by the analysis was done by help of the SPSS version 18 for Windows (SPSS Inc, Chicago, IL, USA) in data cleaning and analysis

Qualitative Data Analysis

Analysis of the qualitative data was based on themes emerging from the participants. The analysis was mainly explanatory and was guided by grounded theory (13)of analysing qualitative data to identify major themes, construct and apply codes, describe thematic attributes and patterns.

Results

Quantitative findings

The study identified a total of 35 (18 from Bahi and 17 from Kinondoni) district health-development partners (excluding national programmes) who were supporting the health sector in the two districts (see Fig. 1). NGOs (International, National and Regional) were the predominant health-development partners in the districts 30 (85%) out of 35 of all development partners. We found no difference in number of DPs between urban and rural District.

16 participants from 16 (46%) development partner organisations participated in a quantitative survey. The characteristics of the respondents are as shown in Table 1.

Table 1
Background Information of IP Respondents (N = 16)

| Type of partner's organization | Total | Bahi | Kinondoni |
|--|-------|------|-----------|
| International NGO | 6 | 2 | 4 |
| National NGO | 6 | 3 | 3 |
| Bilateral project | 1 | 1 | 0 |
| Multilateral project | 1 | 0 | 1 |
| FBO | 2 | 2 | 0 |
| Life span of the current project | | | |
| ≤ 5 years | 5 | 2 | 3 |
| > 5 years | 11 | 6 | 5 |
| Submission of activities to be included in CCHP | | | |
| Yes | 8 | 5 | 3 |
| No | 8 | 3 | 5 |

Six (38%) respondents (three from rural and three urban) reported to have received at least one document (guidelines, policies and other planning tools) from the district for them to use in developing their organization activity plans. CCHP template and guidelines were the commonest documents shared; none reported to have been using district health strategic plan and annual District CCHP in developing their plan. The IP respondents were asked to gauge their organization level of participation in the process of developing their respective district annual health plan (CCHP) as a general view and to specific CCHP development

process. Majority of the respondents from Bahi (87.5%) had partial or substantial participation, while many participants from Kinondoni (62.5%) had not participated at all (zero participation). It was revealed that, out of 35 DPs present in the district, only 17 (48.6%) health DPs had submitted their activities to be included in the CCHP.

Table 2
DPs' Participation to specific areas of CCHP Planning Process (N = 16)

| Stage | Gauge | Total | Rural | Urban |
|---|-----------------------|-------|-------|-------|
| Identifying priority health problems /intervention to be addressed in the 2014/15 CCHP Plan | Zero participation | 5 | 1 | 4 |
| | Partial Participation | 6 | 4 | 2 |
| | Full Participation | 5 | 3 | 2 |
| Allocating resources to the interventions | Zero participation | 5 | 1 | 4 |
| | Partial Participation | 7 | 5 | 2 |
| | Full Participation | 4 | 2 | 2 |
| Developing CCHP Action Plan | Zero participation | 5 | 0 | 5 |
| | Partial Participation | 6 | 5 | 1 |
| | Full Participation | 5 | 3 | 2 |
| Developing the capacity of the Council Health Planning Team | Zero participation | 10 | 5 | 5 |
| | Partial Participation | 4 | 3 | 1 |
| | Full Participation | 2 | 0 | 2 |
| Implementation of CCHP activities | Zero participation | 5 | 0 | 5 |
| | Partial Participation | 4 | 3 | 1 |
| | Full Participation | 7 | 5 | 2 |
| Evaluation and quarterly reporting | Zero participation | 6 | 1 | 5 |
| | Partial Participation | 5 | 3 | 2 |
| | Full Participation | 5 | 4 | 1 |

17 (82.5%) DPs from Bahi district had submitted their plans but majority of DPs, 14 out of 18 (77.7%) from Kinondoni District had not submitted their plans to be included in the annual CCHP (see Table 2).

Review of the CCHP further showed that only 8% of DP activities submitted were included in the CCHP. We also found that 62.5% of the IP respondents from Bahi district perceived the district health planning team capacity to do the planning as excellent compared to 12.5% of Kinondoni district. It was revealed that majority of DPs from Kinondoni district (87.5%) perceived the process as average, low and poor.

DPs' awareness on the Benefits of Engaging their activity plans into CCHP

Figure 2 show that DPs were aware of the benefits for partner organizations to participate and integrate their activities into the district CCHP. Some of the mentioned benefits were: organization visibility that is, recognition of the importance and presence of the organization by the district, getting priorities and areas of working and reducing running costs of an institution due to resources sharing.

Qualitative Findings

The study hypothesized that the implementation of the planning process below the national level might be challenged severely, the fact, which led to the ineffectiveness of the process engagement of DPs into CCHP. Therefore, to expand our understanding to those challenges, we did an in-depth interview (IDI) with 20 participants as shown in Table 3.

Table 3
Characteristics of the IDI Participants

| Characteristic IDI Respondent | Total | Rural | Urban |
|-------------------------------|-----------|----------|-----------|
| Male | 10 | 4 | 6 |
| Female | 10 | 5 | 5 |
| Total | 20 | 9 | 11 |
| District official | 8 | 4 | 4 |
| DP Representative | 10 | 4 | 6 |
| RHMT | 2 | 1 | 1 |
| Total | 20 | 9 | 11 |

Participants mentioned various challenges deterring the DPs from engaging in CCHP. These challenges were both from partners and the government. Below is the summary of the challenges that this study identified and their supporting quotes.

Differences in budget timeline;

"There is a problem of budget timeline. Whereas our financial year ends in June, the financial year of most of our partners start in October. This means that, by the time you engage them, they might say 'we will see what to do' but no commitment. Given these financial year differences, it becomes difficult to submit a paper of what they want to do because, and their donation would then not have been confirmed by their funder" (IDIDO1, Kinondoni).

Low predictability of funding from Prime donors

"One NGO which had never submitted its plan and we even have had not seen them in the field, came to our office asking us to rate them well as an independent assessor was coming for midterm review of the project". (IDIDO3, Bahi).

Inadequate financial allocation for planning activity

"There is a huge challenge on our side as we often don't have the budget to enable our staff to attend, let's say a five day CCHP planning which is usually done outside their district. So we end up by presenting our action plan to CHMT for them to consolidate. However, we do not get feedback from them whether they have included it or not" (" (IDIDP2, Bahi).

"When we invite development partners into the planning, we do not pay them, so those who can pay for themselves we normally accept them and we cooperate with them. Hence, we do not have cost implication except for meal and refreshments that we can accommodate"(IDIDO4, Kinondoni).

Few /irregular meetings

"I have been here for five years and have never been invited even to a single district coordination meeting" (IDIDP3, Bahi).

"We have in our council meeting schedule a quarterly NGO coordination meeting, but we often don't hold these meetings as scheduled due to inadequate financing"(IDIDO2, Kinondoni).

Lack of transparency

"Most development partners are not transparent on their budget. They also never tell you their future commitments to the district. For example, that 'we have this amount of money and we want to do this and that in this area of health" (IDIDO1, Bahi.)

Limited Knowledge and Skills among CHPT on Planning

"Developing a comprehensive council health plan is a technical activity requiring people who are knowledgeable and skilled in planning health-related activities. However, our staffs have not been well exposed to such type of trainings." (IDIDO 3, Bahi).

Lack of Sufficient and Technically Qualified Human Resources among LGAs

"Potential employees, especially recently graduated young ones, do not like to work in the rural areas where there is poor working environment, particularly lack of staff houses, electricity, good office facilities and poor transport"(IDIDO1, Bahi).

Limitations of the Planning Tool (Plan rep)

"The planrep is not flexible to add our partners who do not appear in the planrep version. Therefore, we end up having difficulties entering their plans into planrep. Even in the quarterly reports, we do not report their activities."(IDI DO 2, Bahi).

Discussion

This study examined the engagement of health development partners (DPs) into the district health planning in two districts, representing rural and urban settings in Tanzania. Generally, the findings suggest low participation of DPs in the health planning process at all stages of comprehensive council health planning, with worse situation in urban settings. Important factors explaining this situation include; differences in planning cycles between the government and donors, uncertainties in funding from the prime donors, lack of transparency, limited skills of district planning teams on stakeholder involvement and technical practicalities related to planning tools and processes.

The finding that only few development partners received planning guidance and district priorities to guide planning activities highlights a communication problem between the district planning teams and the development partners. A study by Adsul reported absence of genuine communication or consultation between different actors involved in the district planning process (18). Furthermore, Bonnenberger and colleagues point to inadequate planning and communication skills among district managers. (19) This finding has implication on the participation levels in planning activities and quality of activities included in the plans. Improving communication and coordination through decision support systems and networking among partners working in the same district could help to resolve this problem (20).

We observed a discrepancy in the DPs participation in the planning process between rural and urban settings, with the rural based development partners performing better, which is contrary to our initial assumptions that the urban districts have better planning and coordination capacity than the rural district due to presence of competent human resource. This could be explained by easy visibility of partners in rural settings than their counterparts given the multiplicity of stakeholders working with the district health departments in the urban areas.

The finding that the development partners were aware of the benefits of their involvement in the planning process but did not actually participate in the planning processes is not new and could be explained by the fact that awareness and practice are usually not close if there are barriers of the two to meet. In our study the discrepancy could be explained by the observed operational challenges such as differences in planning cycles between the government and donors, uncertainties in funding from prime donors, lack of transparency, limited skills of district planning teams on stakeholder involvement and technical practicalities related to planning tools and processes. In their paper, Moon and Omole, allude to the Volatility and uncertainty of financing, coordination, priority setting and accountability as a serious limitation of DAH (21).

The inadequate dissemination of national policies and guidelines used for planning observed in this study challenges the role of the Regional Health Management Teams (RHMTs) in supporting districts to develop their CCHP and in disseminating various health policies at the Region and District level. Furthermore, the observation that even when the District DPs submitted their plans to be included in the CCHP; less was reported as actual expenditure from the council health accounts during the quarterly CCHP reports, highlights a discrepancy between the plan and actual expenditure of DPs activities in the studied districts and raises several questions related to what is planned and what is actually implemented and the reasons behind this discrepancy. Future studies should explore the gap.

Methodological Considerations

In this study we use an explanatory mixed methods approach to provide a comprehensive picture of the operational challenges of development partners' involvement in district health planning in Tanzania. As planning is devolved to the health facility level, the study casts light on issues that need to be resolved to enhance partners participation in health planning

Although in this study we compared two districts, we cannot claim generalisability of the results given the limitations of case study design. However, the reader could identify findings that can be transferable beyond the study area.

Conclusions

DPs were engaged in District health planning, however, the level of engagement was low and varied greatly between the two districts with Kinondoni (urban district) having lower scores of DPs engagement at all stages of planning. Local government challenges included, low planning knowledge and skills among CHPT, weak oversight of bodies tasked with approving CCHP, reviewing DPs plans and following implementation of DPs plans; weak consultative structures and coordination mechanisms; low negotiation capacity; lack of clear and adequate communication about local government priorities and inadequate financing to the planning process. Central government challenges included, inadequate dissemination of policies, interference with the autonomy of local governments in planning, weaknesses in supporting districts, featured by inadequate tools for monitoring compliance and lack of clear guidance on planning policies and guidelines to DPs. District DPs challenges included lack of formal leadership to coordinate and network DPs in the district, inadequate knowledge of DPs on government policies and guidelines on planning, heavy reliance on external aid for NGOs resulting in low predictability of funding and interventions being skewed towards donor priorities as well as flagship of donor projects thus making it harder to jointly support the sector.

Abbreviations

CCHP: Comprehensive council Health Plan; CHMT: Council Health Management Team; CHPT; Council health planning Team; DAH: Development Assistance for Health; DHS: District Health system; DP: Development partner; DPG: Development Partners group; IDI: In-depth Interviews; LMIC: Low and Middle income Countries; MOHCDGEC: Ministry of Health, Community Development, Gender, Elderly and Children; NGO: Non-governmental organization; RHMT: Regional Health Management Team; SWAP: Sector wide Approach; UHC: Universal health coverage.

Declarations

Ethics approval and consent to participate

Permission to conduct the study was sought from the Swiss TPH International Health Review Board after approval by the research supervisor. Ethical clearance was also sought from the National Institute for Medical Research in Tanzania. A letter of permission to conduct the study was requested from the relevant authorities. Consent was sought from each research participant before he/she was recruited into the study.

Consent for publication

Not applicable.

Availability of data and materials

All data underlying the findings are fully available without restriction from the corresponding author of this study.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

JC, AH and AK designed the study, JC implemented the study and collected the data, JC, AH and AK analysed the data and KU prepared and edited the final document. All authors read and approved the final manuscript.

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Figures

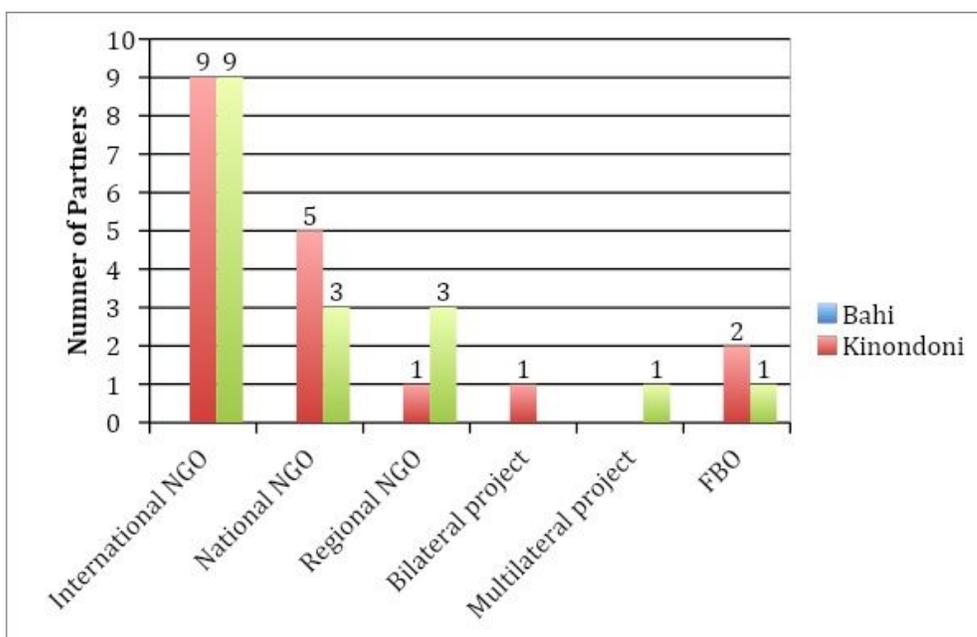


Figure 1

Type of Developing Partners (DPs)

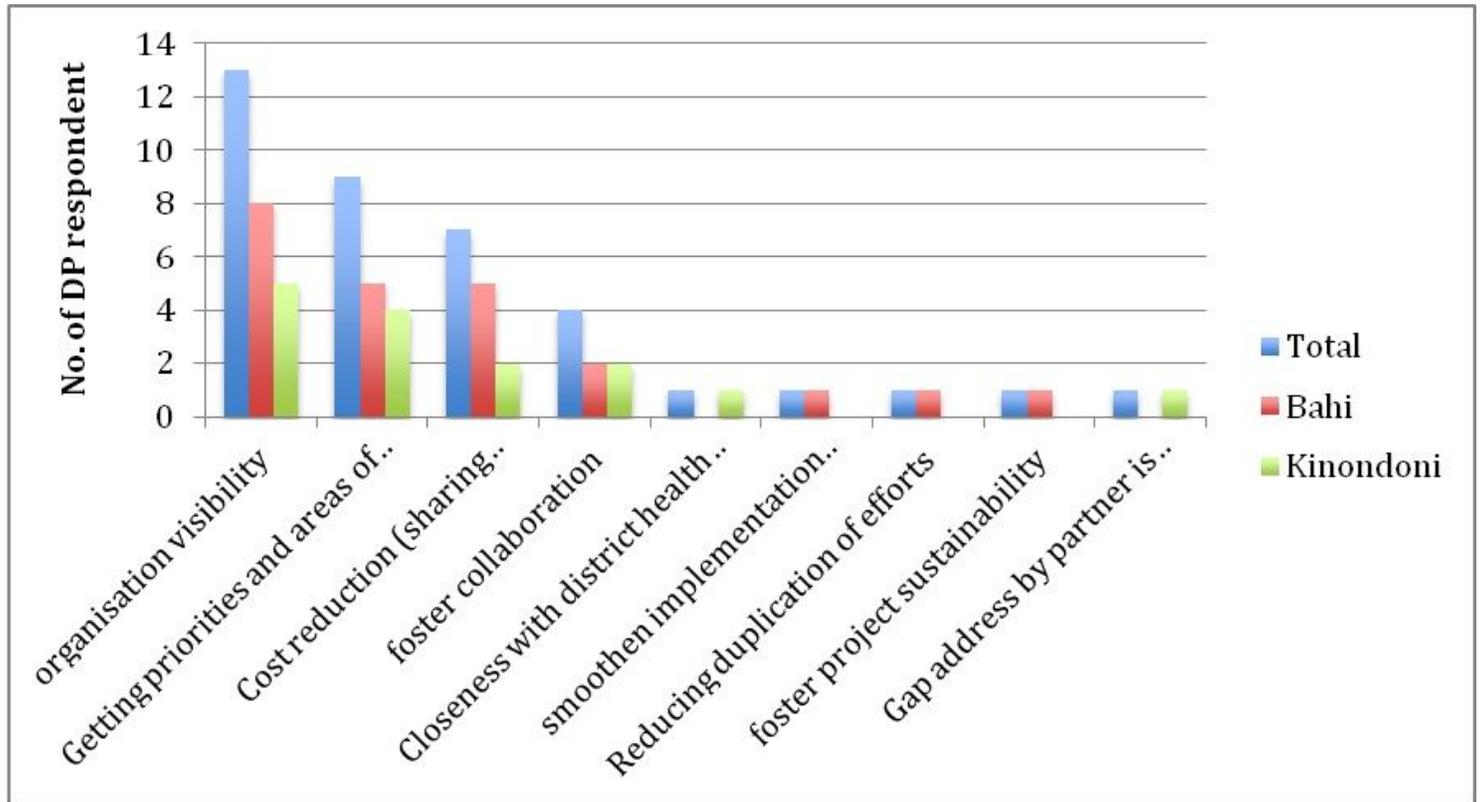


Figure 2

DPs' Perceived Benefits of Engaging in CCHP