Title: Engaging citizens in planning, budgeting, and financial management to improve health service delivery

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Context

Tanzania has a decentralization by devolution (D&D) policy whereby delivery of services is anticipated to be informed and managed through a high level of citizen engagement. Despite the good intentions of the decentralization by devolution policy, community health needs, especially the needs for women, youth, and low-income people are not being effectively translated into their decentralized health sector plans and budgets. Community members are independent decision-makers and their voices should be heard during the planning and budgeting process. There is limited capacity of community members and health facility governing committees to actively engage and take part in the planning and budgeting processes. Funds are not allocated and managed by frontline service providers and lower-level government (councils/community, villages, and wards) because of a lack of sound financial management systems. Planning, budgeting, and expenditure management systems currently stop at the council level. This hinders the ability of frontline service providers and lower-level government plans to align and manage resources to respond to the varying needs of the community groups.

Activity Description

Our experience of working closely with people passionate and committed to improved health systems and facilities delivery where citizens were seeking to improve health decision making. We achieved our mission such as planning and budgeting at the local level because they were the key entry points for ensuring citizens voices are prioritized and incorporated into decisions made about health service delivery. We worked with different levels of government responsible for health service delivery (national, regional, local government authorities), civil society (through community health alliance and health civil society), community members, and their leaders. Through our work, we have been able to align the tasks in order to make the people aware of the priority health sectors, initially the planning process was only focusing on planning for inputs (e.g., per diems, minimal development) and were only generating plans or budgeting plans that focused on the national level. The ability to develop plans and budgets that reflect the priority needs of the community was not effective in engaging citizens to develop plans that align their resource allocation to priority health outputs. Initially, the planning process was only focusing on planning for inputs (e.g., per diems, minimal development) and were only generating plans or budgeting plans that focused on the national level. The ability to develop plans and budgets that reflect the priority needs of the community, the system also helps in linking and prioritizing community needs and it helps to bridge critical gaps identified in the community. It also facilitates the engagement of health facilities in planning and budgeting processes.

Activity Impact

The advancement of the health management information system (HMIS) and planning and budgeting systems showed that drug stock-out has decreased following the introduction of DFF and FFARS. Funds are more effectively translated into community level plans and budgets. Health facilities and village governments are also increasingly engaging. Facility financial management systems now have necessary inputs required to deliver services. Money is now available to facilitate delivery of priority health services to the community in each financial year. Our ability to provide services has increased significantly, we have increased our budget autonomy that aligns our budget with the facility and allows us to access good quality and service delivery. Priorities are now reflected in the plans and budgets that are developed by health facilities and village governments.

Evidence

The introduction of the Tanzania Health Operation Management Information System (TANHMIS) has helped to improve the quality of service delivery. The introduction of government of Tanzania health operation management information system (GOTHOMIS) has helped to improve the quality of service delivery. Furthermore, the introduction of Federal Financial Accounting Reporting System (FFARS) supported the government's initiative to engage CSOs and community-owned radios to build the capacity of communities to engage and negotiate in sessions to develop plans and budgets. This has hinders the ability of frontline service providers and lower-level governments to plan and manage their resources to respond to the varying needs of the community groups.

Challenges

Limited IT infrastructure (e.g., internet, computer) for effective use of improved systems (PlanRep, FFARS) across all levels. Some facilities lack access to internet and computer systems for accessing health information systems. There is a high turnover among facility staff who have access to limited IT infrastructure for effective use of improved systems. Frontline service providers need to be at the core of system strengthening interventions. It is necessary to link system reforms to the objective of improving health service delivery. The government has been willing to cost share implementation costs. The government was willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems "Willingness of the government to cost share implementation costs. Furthermore, the government has been willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems. The government was willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems. No need to print plans and budget for scrutinization. The web-based PlanRep has proved to be a sustainable practical tool that aligns resource allocation to priority health outputs. Health and financial management systems at facility and council levels now have necessary inputs required to deliver services. The government was willing to cost share implementation costs. The government was willing to cost share implementation costs. Furthermore, the government has been willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems. The government was willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems. The government was willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems. The government was willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems. The government was willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems. The government was willing to cost share training costs (e.g., per diems, minimal development) and facility financial management systems.

Lessons Learned

System strengthening interventions have been holistically evaluated to understand what they are delivering and what is the impact on essential health service delivery. System strengthening interventions have been holistically evaluated to understand what they are delivering and what is the impact on essential health service delivery. System strengthening interventions have been holistically evaluated to understand what they are delivering and what is the impact on essential health service delivery. System strengthening interventions have been holistically evaluated to understand what they are delivering and what is the impact on essential health service delivery. System strengthening interventions have been holistically evaluated to understand what they are delivering and what is the impact on essential health service delivery. 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