THE UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH

FINAL REPORT

MID - TERM REVIEW OF THE HEALTH BASKET FUND FUNCTIONALITY AT ALL LEVELS FOR THE FY 2020/21 TO DECEMBER 2023.

ABBREVIATIONS

BoT	Bank of Tanzania
CCHP	Comprehensive Council Health Plans
CHE	Current Health Expenditure
CHF	Community Health Fund
DHFF	Direct Health Facility Financing
DHIS2	District Health Information System 2
DPs	Development Partners
eLMIS	Electronic Logistics Management Information System
FFARS	Facility Financial Accounting and Reporting System
FY	Financial Year
GoT	Government of Tanzania
GoTHOMIS	Government of Tanzania Hospital Operation Management Information System
HBF	Health Basket Fund
HMIS	Health Management Information System
HSSP V	Health Sector Strategic Plan V
iCHF	Improved Community Health Fund
IFMIS	Integrated Financial Management Information System
LGA	Local Government Authority
MoH	Ministry of Health
MoF	Ministry of Finance
MSD	Medical Stores Department
MTR	Mid-term Review
MUSE	Mfumo wa Uhasibu Serikalini (GoT Accounting Software)
NHIF	National Health Insurance Fund
NSA-H	Non-State Actors for Health
PHC	Primary Health Care
PforR	Programme for Results
PlanRep	The United Republic of Tanzania Planning and Reporting System
PO-RALG	President's Office – Regional Administration and Local Government
PPP	Public-private Partnership
RHMTs	Regional Health Management Team
SARA	Service Availability and Readiness Assessment
THE	Total Health Expenditure
UHC	Universal Health Coverage
URT	United Republic of Tanzania

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0. EXECUTIVE SUMMARY

Background

This Mid-Term Review (MTR) of the Health Basket Fund (HBF) in Tanzania was commissioned by the Ministry of Health (MoH) of the United Republic of Tanzania (URT), contracted through United Nations Children's Fund (UNICEF), and implemented by the Swiss Tropical and Public Health Institute (Swiss TPH). The objective of the review was to assess the relevance, effectiveness, efficiency, equity, sustainability, and coherence of the HBF in contributing to Tanzania's health sector goals - with a particular focus on Primary Health Care (PHC).

The HBF has been a cornerstone of on-budget health financing for over two decades, providing pooled funds to central ministries, regional and local government authorities. Its mission is to strengthen public health systems and expand access to essential services, especially at the PHC level and for underserved populations in rural areas. This review assesses progress and performance under the current Health Sector Strategic Plan V (HSSP V), within the broader context of Universal Health Coverage (UHC) reforms. The review also serves as a critical input into Tanzania's ongoing UHC and Universal Health Insurance (UHI) reforms, ensuring that the HBF evolves in alignment with new financing frameworks.

Methodology

The MTR employed a mixed-methods approach to triangulate evidence from three main sources:

- **Document and policy review** of strategic frameworks, budgets, implementation guidelines, and previous assessments.
- **Quantitative analysis** of disbursement data, allocation formulas, expenditure trends, and performance indicators, primarily from the Facility Financial Accounting and Reporting System (FFARS), the '*Mfumo wa Uhasibu Serikalini*' (MUSE, GoT Accounting Software), and Health Management Information System (HMIS).
- **Qualitative fieldwork**, including over 160 key informant interviews and focus group discussions with stakeholders from national ministries, Development Partners (DPs), Council Health Management Teams (CHMTs), health facilities (hospitals, health centres, dispensaries), and community governance structures.

The review was designed to ensure geographic representativeness and thematic coverage across Tanzania's health system. All findings were validated through triangulation of sources and stakeholder feedback loops.

Key Findings

The Mid-Term Review (MTR) confirms that the HBF continues to play a pivotal role in Tanzania's health financing architecture, particularly in supporting PHC at the facility level. The HBF is valued for its contributions to decentralization, integration of donor financing into government systems, and support for equity and results-based planning and budgeting.

The findings of the MTR reflect a complex reality - marked by significant achievements and persistent systemic barriers. The summary below distinguishes between the areas of progress and ongoing challenges that shape the effectiveness of the HBF. The MTR findings demonstrate that the HBF continues to deliver substantial value to the health sector.

The following achievements reflect areas where the fund has contributed meaningfully to PHC delivery and system strengthening:

Achievements and Positive Findings:

- **High Relevance and Alignment:** The HBF is well-aligned with Tanzania's national health strategies, particularly the HSSP V and the government's commitment to UHC.
- **Strengthened Facility Autonomy:** The Direct Health Facility Financing (DHFF) mechanism has enhanced local ownership, enabling facilities to plan and manage their resources based on local priorities.
- **Digital Systems and Financial Transparency:** The implementation of digital tools such as the governmental Planning and Reporting System (PlanRep), FFARS, and the Government of Tanzania Hospital Operation Management Information System (GoTHOMIS) has improved planning, reporting, and financial accountability at all levels.
- **Support to Community Engagement:** The HBF has strengthened the role of Health Facility Governing Committees (HFGCs), promoting participatory governance and enhancing accountability at the local level.
- **Contribution to Health System Strengthening:** The HBF has facilitated investments in infrastructure, service availability, and capacity-building at the primary level, including in rural and underserved areas.
- **Donor Coordination and Integration:** The Fund has served as an effective platform for donor harmonization and integration of external support into government systems, reducing fragmentation.

Core Challenges and Systemic Issues

Despite its strengths, the HBF's effectiveness is constrained by a number of structural and operational challenges:

- **Disbursement Delays:** HBF funds are consistently released months after the fiscal year begins, disrupting implementation of annual workplans. The procedural link between the Internal Auditor General (IAG) performance report and the signing of side agreements remains a key bottleneck. During the financial year 2023/2024, donor funds were continuously deposited into the Holding Account at the Bank of Tanzania (BoT). In 2023, funds were wired in August, October, and November. In 2024, additional funds were transmitted in January, March, and June.
- **Delays from Ministry of Finance (MoF, formerly MoFP) to the Local Government Authorities (LGAs)**: Once the funds are released by the DPs, time is needed for disbursement to the Local Government Authorities (LGAs). These delays are due to various governmental procedures. In the first quarter, the President's Office - Regional Administration and Local Government (PO-RALG) requested a fund transfer from the Treasury to the Local Government Authority (LGA) and health facility accounts on September 15, 2023. The health facility received the funds on October 24, 2023. In the fourth quarter, PO RALG submitted another fund transfer request on March 1, 2024, with the funds arriving at the health facilities on June 3, 2024. These disbursements just before the end of the Financial Year (June 30th) severely disrupt the implementation of the health facility activity plans within the financial year.

- **Equity Gaps in Allocation:** The current allocation formula and performance-based indicators inadvertently disadvantage low-capacity or hard-to-reach facilities, particularly dispensaries and councils in remote areas.
- **Fragmented Funding and Reporting Burdens:** PHC facilities often manage multiple funding sources with distinct planning and reporting requirements, imposing a heavy administrative load on clinical staff with limited support. In addition, existing expenditure rules and earmarks tied to specific funding sources limit facilities' ability to implement their integrated annual plans flexibly. Harmonizing these rules - so that HBF, UHI, and other funds can all contribute to the same comprehensive facility plan and budget - is essential to unlocking the full potential of blended financing.
- **Rigid Expenditure Rules:** Fixed spending ratios (e.g., 35% of the HBF funds are earmarked for medicines) may no longer reflect local needs, especially where government health supply chains have improved. This limits facility-level flexibility to utilize funds for other priority needs.
- **Transition to UHI Brings Opportunities and Risks:** The UHI Act (2023) offers major potential to expand financial protection, but its rollout must ensure that UHI reimbursements, HBF allocations, and other public funds can be used flexibly within a single, comprehensive facility activity plan covering preventive, promotive, curative, and administrative needs. While integrated plans already exist through national tools (PlanRep, FFARS), source-specific spending rules still constrain flexibility. Analysing and where possible removing these barriers, safeguarding financing for exempt groups through the planned Equity Fund, and integrating UHI and HBF within shared quality improvement and monitoring frameworks will be critical to sustaining equity and service continuity during the transition.

These findings inform the strategic recommendations presented below, which aim to consolidate the Fund's strengths while addressing operational constraints and supporting alignment with broader UHC reforms.

Strategic Recommendations

To enhance the effectiveness and future sustainability of the HBF, the MTR proposes a set of strategic reforms:

- **Reform Fund Flow Mechanisms**: Finalize IAG Terms of Reference earlier in the fiscal cycle (by December). Delink IAG performance reports from fund disbursement for non-results-based contributors. Adopt phased or conditional disbursement models to minimize disruptions where first disbursements are made before the final report of the IAG is provided. Also result-based contributors (e.g. World Bank) could agree to disburse a first tranche of funding before the final report of the IAG is received which then would determine the final payment on performance basis. Participants at the national level felt that the establishment of an electronic system to monitor the whole fund flow process would enhance the timely processing of disbursement steps by the various actors involved and also promote transparency of the process and overall accountability. This tracking tool could be developed similar to other such tracking tools already used by the Government.
- **Improve Equity in Resource Allocation**: Reinstate a base allocation for all facilities and introduce an "equity window" to support underserved or low-performing areas. Review performance indicators to avoid unintended disincentives or distortions.

- **Simplify Financial Management and Reporting:** Harmonize planning and reporting templates across all the funding pots to the LGAs and improve interoperability among key systems (FFARS, PlanRep, GoTHOMIS, openIMIS) via national health information platforms.
- **Enhance Spending Flexibility:** Revise the rigid expenditure ceilings to allow context-specific reallocation based on actual service delivery gaps and stock levels. Prescriptive spending rules, notably the 35% earmark for medicines and equipment for the use of HBF funds, are increasingly misaligned with current needs as central government supply of medicines via the Medical Stores Department (MSD) and the Jazia Prime Vendor System improves.
- **Strategically Position HBF Within UHI Reforms:** Ensure continued public financing for essential PHC services not covered by insurance and strengthen purchasing capacities to manage blended financing mechanisms. Ensure that subsidies for exempt groups are fully financed and operationalized (Equity Fund). Promote the integration of HBF and UHI reimbursements into broader quality improvement frameworks at facility level - irrespective of the source, all funds should finance a comprehensive health facility activity plan which includes also promotive and preventive care as well as the required expenditures in maintaining or improving the quality levels for the facility.
- **Develop and institutionalize UHI monitoring tools** to track membership uptake, claims flows, and financial performance at national, regional, and LGA levels. These should be integrated into existing dashboards and made accessible to local managers to inform annual planning, equity allocation adjustments, and joint HBF-UHI performance reviews.
- **Bolster Community Ownership and Accountability:** Reinforce the functionality of HFGCs through capacity-building and provision of tools that enable them to participate meaningfully in planning, budgeting, and monitoring processes.

To complement the thematic analysis, the Mid-Term Review also assessed the HBF's performance against the OECD-DAC evaluation criteria. The summary below highlights how the Fund performs across these dimensions.

Assessment Against DAC Evaluation Criteria

Criterion	Assessment Summary	Evidence Sections
Relevance	The Health Basket Fund remains highly relevant to Tanzania's national health priorities, particularly the goals outlined in the HSSP V and the Primary Health Care roadmap. The HBF has enabled a decentralized financing model that supports essential service delivery at the facility level and aligns with the policy goal of "leaving no one behind." It also contributes to Tanzania's UHC agenda by financing services for populations not covered by insurance. Key informants affirmed that HBF complements both national policy direction and emerging financing reforms, such as UHI.	Section 3.1, 3.2, and 3.3
Effectiveness	HBF financing has enabled significant service delivery outputs, particularly in PHC facilities, and supported the availability of medicines, outreach services, and essential health commodities. However, disbursement delays and rigid expenditure ceilings weaken	Section 3.4, 3.5, 3.9

Criterion	Assessment Summary	Evidence Sections
	responsiveness at facility level. Results-based allocation has incentivized performance, but the indicators used are sometimes misaligned with the service mandate of lower-level facilities. Better-equipped health centres and hospitals have the advantage of attracting more clients compared to under-resourced facilities in terms of medicines, medical supplies, equipment, and staffing to handle complications.	
Efficiency	While the HBF ensures predictable and formula-based allocations, its full efficiency is compromised by procedural bottlenecks. One bottleneck occurs through the role of the IAG performance report as a precondition for the payments of DP contributions. A second major bottleneck consists of delays on the side of government after disbursements of funds from the DPs, which often leads to substantial delays of the funds reaching LGAs and health facilities. Further obstacles are created through multiple and duplicative reporting burdens at health facility level and limited flexibility in reallocating funds to emerging priorities at that level. Further, facility in-charges especially at dispensary level often manage financial reporting, procurement, and patient care without administrative support, limiting operational efficiency and data quality.	Section 3.3, 3.4, 3.8
Sustainability	The upcoming rollout of UHI represents a major shift in Tanzania's health financing system. The long-term sustainability of the HBF will depend on its ability to complement UHI by addressing equity gaps. While UHI reimbursements are tied to service delivery - mainly curative services - HBF can channel resources to facilities that are disadvantaged by geography, staffing shortages, or low population density. Rather than being driven by service volume, HBF can apply equity-based allocation criteria and introduce targeted budget lines for under-resourced facilities, as proposed in this report. This positions the HBF as a vital mechanism for financing non-insurable PHC services and maintaining service quality across the system. Importantly, funding source should not determine utilization. All funds - regardless of origin - should contribute to a unified, comprehensive facility activity plan. In parallel, the financial sustainability of the HBF itself remains a concern. Current funding levels are heavily donor-dependent, and domestic fiscal space for PHC is uncertain. A clear transition roadmap is needed to align HBF with UHI and other financing streams, safeguarding support for public goods and equity during the ongoing reform process.	Section 3.7
Impact	The HBF has had measurable positive impact on expanding health access in rural areas, strengthening planning at local level, and institutionalizing community governance mechanisms. Increased autonomy for facilities under DHFF has fostered a sense of	Section 3.6, 3.10

Criterion	Assessment Summary	Evidence Sections
	ownership, while the HFGCs have enhanced citizen engagement. However, uneven functionality of HFGCs and disparities in fund allocation to underserved areas limit the HBF's equity-enhancing potential.	
Coherence	The HBF demonstrates internal coherence by harmonizing funding from multiple DPs through a pooled mechanism using national systems. However, fragmentation persists between the HBF, Results Based Financing - RBF - now referred to as Programme for Results (PforR), NHIF and iCHF reimbursements (phasing out as memberships transition to UHI), and vertical donor programs. This undermines administrative efficiency and creates parallel reporting lines. The limited interoperability among digital systems (PlanRep, FFARS, GoTHOMIS, openIMIS) further complicates financial coherence at the facility level.	Section 3.1, 3.5, 3.8

Conclusion

Overall, the HBF remains a foundational platform for delivering equitable, quality PHC in Tanzania. As the country embarks on the implementation of UHI and other health sector reforms, the HBF must be repositioned to complement insurance financing, safeguard essential services, and drive inclusive health system strengthening. The recommendations of this MTR provide a roadmap to strengthen HBF's strategic relevance, operational efficiency, and long-term sustainability. Ensuring that harmonized expenditure rules and integrated monitoring frameworks are embedded in policy will be critical for sustaining the HBF's role as an equity-focused platform within a blended, comprehensive PHC financing model.

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1. INTRODUCTION

1.1 Objectives and Purpose of the Mid-Term Review (MTR)

This Mid-Term Review (MTR) was commissioned by the Ministry of Health (MoH) of the United Republic of Tanzania, funded by UNICEF, and implemented by the Swiss Tropical and Public Health Institute (Swiss TPH) between December 2024 and June 2025. The primary objective was to assess the performance, relevance, efficiency, and sustainability of the Health Basket Fund (HBF), with a particular focus on its contribution to Primary Health Care (PHC) and the progression towards Universal Health Coverage (UHC) in Tanzania.

The review aims to identify systemic strengths and weaknesses, evaluate progress under current arrangements, and provide actionable recommendations to enhance the HBF's functionality and alignment with Tanzania's evolving health financing landscape. It serves both accountability and learning purposes, informing stakeholders' decisions regarding the future direction of HBF programming and reforms.

1.2 Scope of the Review and Key Policy Questions

The MTR encompasses the period from Financial Year (FY) 2020/21 through 2023/24, assessing HBF performance at national, regional, council, and facility levels. The review focuses on governance, fund flow, equity of allocation, service delivery performance, and coherence with ongoing health sector reforms.

Key policy questions include:

- How effectively does the HBF support the delivery of PHC services across Local Government Authorities (LGAs)?
- Is the allocation formula equitable and context-sensitive?
- How well is the HBF aligned with other financing mechanisms, including the Universal Health Insurance (UHI)?
- What technical and structural bottlenecks undermine the impact of the HBF?
- What reforms are necessary to enhance its contribution to sustainable health financing?

These questions are aligned with the OECD-DAC evaluation criteria (relevance, effectiveness, efficiency, sustainability, coherence, and impact), ensuring comparability with global development evaluation standards.

1.3 Context: Tanzania's Health Sector, PHC, and UHC Goals

Tanzania has made significant strides in strengthening its PHC system as part of broader efforts to achieve UHC. The Health Sector Strategic Plan V (HSSP V) for 2021–2026 outlines a renewed commitment to decentralized service delivery, prioritization of vulnerable populations, and more efficient use of public and external health financing mechanisms.

The HBF, established more than two decades ago, has evolved into a central pillar of Tanzania's on-budget, pooled financing architecture. It complements government funding by providing

predictable, supplementary resources to sectoral and central ministries, as well as regional and local government authorities. The HBF is governed under a formal Memorandum of Understanding (2021–2026) between the Government of Tanzania and Development Partners and is jointly coordinated by the Ministry of Health (MoH), President's Office – Regional Administration and Local Government (PO-RALG), and the Ministry of Finance (MoF).

A cornerstone reform supported by the HBF is the Direct Health Facility Financing (DHFF) mechanism, introduced in 2017/18. DHFF channels funds directly to primary-level facilities - dispensaries, health centres, and district hospitals - to strengthen local ownership and operational efficiency. DHFF enables facilities to manage multiple revenue streams, including the HBF, user fees, development partner support, and insurance reimbursements (NHIF, iCHF – in future integrated in the UHI). Key digital platforms underpinning DHFF include:

DHFF is supported by an interconnected suite of digital platforms:

- **PlanRep** (Planning and Budgeting System): A web-based system used by Local Government Authorities (LGAs) and health facilities to develop and submit facility-level budgets and workplans during the Comprehensive Council Health Plan (CCHP) cycle. Studies note that its interoperability with government financial systems like Epicor reduces planning time by ~90% (Ruhago *et al.,* 2022).
- **FFARS** (Facility Financial Accounting and Reporting System): An on- and offline-enabled accounting tool designed to record facility budgets, financial transactions, bank reconciliations, and expenditure reports. FFARS automatically exports budget execution data to PlanRep and Epicor at the council level, improving accuracy and transparency in facility-level finances (Ruhago *et al*., 2023).
- **GoTHOMIS** (Government of Tanzania Health Operations Management Information System): A facility electronic registry that captures clinical service delivery data and feeds into national health information systems, including DHIS2 (Kinyenje *et al*., 2023).
- **eLMIS** (electronic Logistics Management Information System): Facilitates medical supplies procurement and stock monitoring, complementing the logistics chain. As JSI (2015) notes, the implementation of eLMIS in Tanzania has provided end-to-end supply chain visibility, enabling data-driven decisions for procurement planning and replenishment at the facility level (John Snow Inc., 2015).

The combined use of these platforms marks Tanzania's strategic pivot toward digitization and results-oriented financial governance. Evaluations confirm that PlanRep and FFARS have notably improved efficiency and accountability in facility-level management.

Importantly, the HBF employs a pro-poor, equity-sensitive allocation formula—based on population size, distance to services, poverty levels, and disease burden—to promote more equitable distribution of resources across LGAs (see Section 3.3). Since 2016, the fund has also adopted performance-based allocation mechanisms, with results tracked at LGA and facility levels through the HBF Scorecard (see Section 3.1.4).

The enactment of the UHI Bill in 2023 represents a major shift in Tanzania's health financing landscape. UHI aims to extend financial protection to previously uninsured and exempted groups by gradually integrating the National Health Insurance Fund (NHIF) and the improved Community Health Fund (iCHF) under a unified national insurance framework. In this transition, the HBF remains critical—not only in ensuring minimum service guarantees for underserved populations

but also in financing non-insurable services, public health goods, and essential PHC inputs that fall outside the insurance benefit package.

Despite this progress, Tanzania's health system continues to grapple with persistent challenges, including workforce shortages, infrastructure constraints, underfunding of preventive and promotive services, and fragmented reporting and accountability structures. This Mid-Term Review provides an opportunity to assess how the HBF can be optimized to respond to these systemic bottlenecks while complementing the broader UHC and health financing reform agenda.

1.4 Evolution and Governance of the Health Basket Fund

Since its inception in 1999, the HBF has been a cornerstone of on-budget health financing in Tanzania, embodying the Sector-Wide Approach (SWAp) by coordinating technical and financial support from Development Partners (DPs). The current Memorandum of Understanding (MoU) for 2021–2026 governs the cooperation between the Government of Tanzania and seven DPs: the Embassy of Switzerland, Korea International Cooperation Agency (KOICA), Danish International Development Assistance (DANIDA), UNICEF, Ireland, Global Affairs Canada, and UNFPA. Notably, DANIDA, initially expected to exit at the end of 2022/2023, continued contributions through the DANIDA Investment for 2023/2024 (URT, 2021f). The World Bank is one of the long-term DPs; however, its formal participation under the current MoU began in the 2023/2024 financial year, followed by the Foreign, Commonwealth and Development Office (FCDO) in FY 2024/2025.

The HBF utilizes the government Exchequer mechanism, adhering to government procedures, regulations, and financial rules in planning, implementation, monitoring, auditing, and reporting. At the district level, funds are allocated to all 184 districts based on an equity resource allocation formula: 60% according to population, 20% to the length of the official medical vehicle route to health facilities, 10% to the estimated number of poor residents, and 10% to the estimated morbidity count in each LGA, based on the under-five mortality rate.

Over the years, the HBF has undergone significant reforms. Prior to 2004, funds were allocated on a per capita basis. In 2004, an equity-based formula was introduced, later adjusted in 2015 to account for geographical differences. The shift from input-based disbursement to performance-based funding began with the 2016–2020 MoU and continues under the current MoU which links disbursements to the achievement of performance targets summarized in the HBF scorecard (URT, 2016a). The institutionalization of digital systems such as PlanRep, FFARS, GoTHOMIS, and the integration into government Exchequer flows represent significant advancements in aligning external resources with domestic financial systems. The introduction of performance-based allocation (since 2016) and DHFF (since 2017/18) are key reform milestones in the operational evolution of the HBF.

1.5 Direct Health Facility Financing (DHFF) and Digital Systems

The introduction of DHFF in FY 2017/18 marked a major shift in Tanzania's public financial management. Under DHFF, health facilities receive funds directly into their accounts based on approved plans, enabling them to plan, manage, and report expenditures at the point of service delivery. The mechanism covers various funding sources, including the HBF, user fees, CHF/iCHF contributions, NHIF reimbursements, and other DPs that are not contributing through HBF.

While DHFF has significantly strengthened local ownership, accountability, and timely access to funds at the facility level, it has also posed new administrative and technical challenges. Health facility staff, especially at the dispensary and health centre levels, are often tasked with complex financial management duties without adequate administrative support.

To support this decentralised financial management structure, several digital platforms have been rolled out:

- **PlanRep** (Planning and Reporting Tool): Used for budget preparation and projection during the CCHP cycle.
- **FFARS** (Facility Financial Accounting and Reporting System): Supports real-time financial tracking at facility level, capturing expenditures and reporting data for integration with national systems.
- **GoTHOMIS** (Government of Tanzania Hospital Management Information System): Records service delivery and clinical data for integration into the national DHIS2.
- **MUSE** (‘*Mfumo wa Uhasibu wa Serikali’*): Serves as the broader government accounting platform.
- **openIMIS**: A digital insurance management system piloted under iCHF, facilitating claims processing and reimbursement at the PHC level.

These systems are being integrated through the ‘*Muungano’* Gateway and the Health Information Mediator (URT, 2022a; Kuwawenaruwa *et al*., 2023), which aim to enable seamless data exchange between financial, planning, service delivery, and insurance platforms. However, interoperability remains a work in progress, and many facilities still face duplicative data entry and fragmented reporting demands, as highlighted in Chapter 3.8.

Furthermore, the HBF also incentivizes the functionality of Health Facility Governing Committees (HFGCs) by providing allowances for participation in planning and budgeting processes. These community-level governance structures play a growing role in ensuring accountability and transparency, although their capacity varies across regions (see Chapter 3.10).

Despite improvements, fieldwork revealed continued gaps in digital literacy, equipment availability, and alignment between platforms like PlanRep and FFARS which are both present at facility level. Ongoing training, system interoperability upgrades, and administrative support for facility staff are needed to sustain the gains made under DHFF.

1.6 Health Financing Landscape and Challenges

Tanzania’s health financing landscape is shaped by a mix of public, donor, out of pocket and insurance-based resources. These are channelled through various mechanisms, including the Health Basket Fund (HBF), Programme for Results” (PforR), government development funding, and health insurance schemes such as the NHIF and the iCHF.

The HBF remains a cornerstone of on-budget external assistance, enabling broad support for PHC and system strengthening. It uses an equity-based allocation formula, with a portion of disbursements linked to performance, thereby reinforcing strategic purchasing at the LGA level.

Health insurance schemes, particularly NHIF and iCHF, provide additional revenue to health facilities, especially hospitals and higher-level centres. However, coverage remains limited,

particularly among rural and poor populations, and reimbursements are often delayed or insufficient to fund preventive and promotive services.

Despite this range of financing mechanisms, significant challenges persist:

- **Disbursement Delays**: The dependency on the Internal Auditor General's (IAG) report and side agreement signing contributes to late disbursements from the HBF.
- **Rigid Spending Rules**: Fixed expenditure ceilings (e.g., 35% for medicines) limit responsiveness to local priorities.
- **Fragmented Funding and Reporting**: Facilities often manage over 10 separate funding streams with unaligned planning, reporting, and accounting processes.
- **Equity Concerns**: Performance-linked financing may disadvantage lower-capacity or hard-to-reach areas unable to meet performance thresholds (see Section 3.3).
- **Sustainability Questions**: Donor contributions to the HBF have fluctuated in recent years. While the UHI law provides a pathway for domestic resource mobilization, it is still in early stages of implementation and may not yet replace external support for key PHC functions.

Tanzania stands at a strategic crossroads: while its health financing mix has grown in sophistication, greater integration and alignment across funding streams are essential to sustain equity and efficiency, particularly during the UHI transition. The HBF remains vital for maintaining the public good aspects of health care and filling financing gaps for non-insurable services.

1.7 Structure of the Report

This MTR report is structured to provide a comprehensive yet policy-relevant assessment of the Health Basket Fund's performance and strategic positioning within Tanzania's evolving health financing context. The structure is designed to follow a logical flow from background and evidence to synthesis and recommendations, while meeting both technical and policy-maker needs.

- **Chapter 1: Introduction**: Provides background to the MTR, including objectives, policy context, and the structure of the report.
- **Chapter 2: Methodology**: Outlines the mixed-methods approach applied, including desk review, key informant interviews, facility surveys, and financial data analysis. It also aligns the evaluation design with the OECD-DAC criteria.
- **Chapter 3: Empirical Findings**: Presents the full results of the MTR, organized thematically by key operational domains of the HBF—such as governance, financing flows, disbursement practices, reporting systems, and integration with national reforms. Evidence is drawn from both primary and secondary data sources.
- **Chapter 4: Key Findings and Strategic Issues**: Synthesizes the major achievements and challenges identified, grouped around strategic themes such as equity, sustainability, coherence, and accountability. For each issue, it presents the core problem, underlying causes, potential solutions, and strategic tensions.
- **Chapter 5: Conclusions and Strategic Recommendations**: Summarizes the conclusions drawn from the findings and provides actionable recommendations. It

includes a section interpreting the results through the lens of OECD-DAC criteria, as required by the Terms of Reference.

- **Annexes**: Include supplementary tables, full lists of indicators, survey tools, and additional technical materials.

This structure supports both a content-driven analysis - suitable for policy action - and the evaluation requirements of Development Partners and Government stakeholders.

2. METHODOLOGY

This chapter outlines the evaluation framework, study design, data sources, and methods used in the MTR of the HBF, including limitations and mitigation strategies. The methodology was designed to ensure a comprehensive, participatory, and evidence-based assessment that addresses the core review questions outlined in the Terms of Reference (ToR).

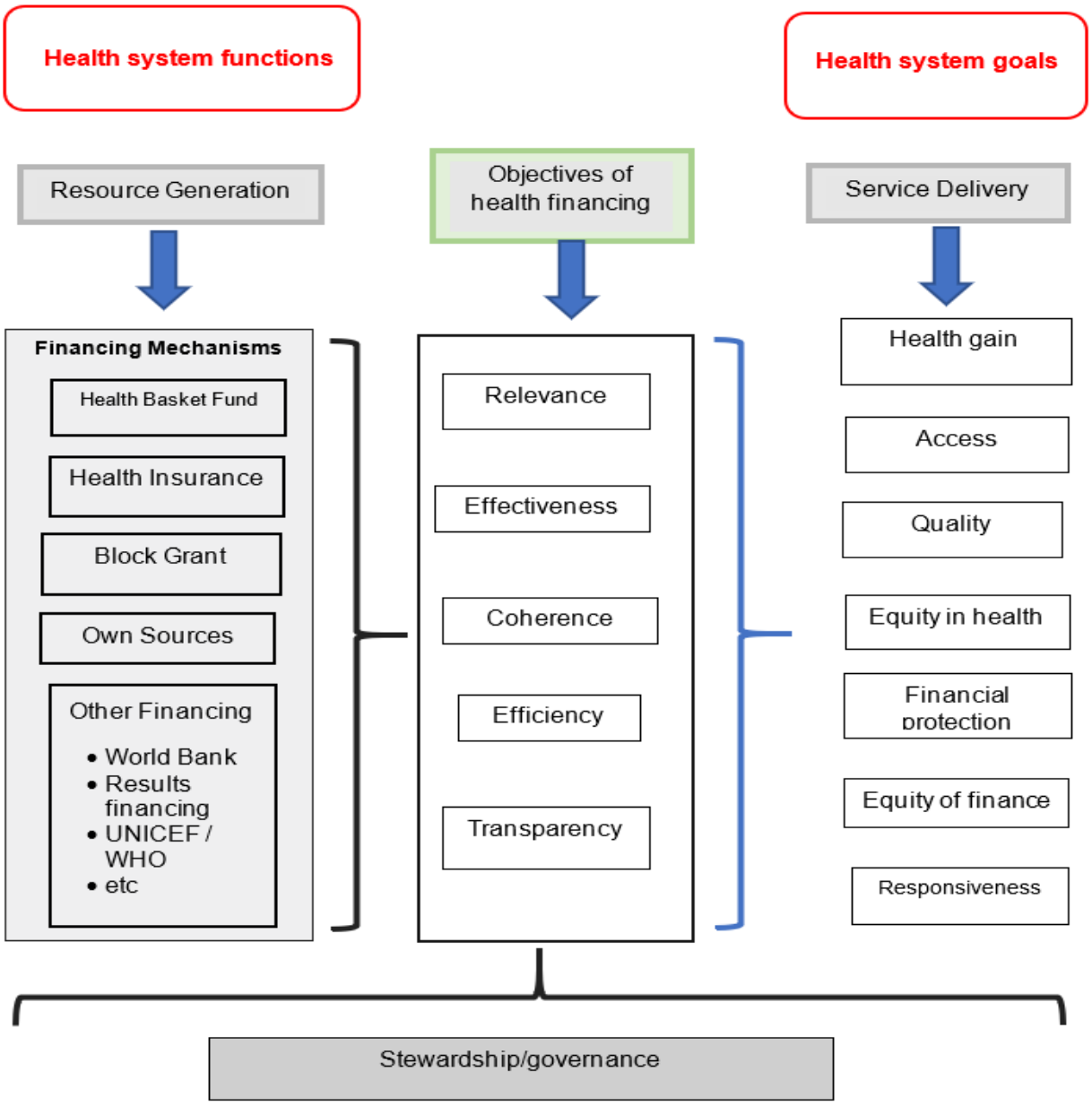
2.1 Overview of Evaluation Framework and DAC Criteria

The review applied the internationally recognized OECD-DAC evaluation criteria , adapted to the specific context of Tanzania's HBF:

- **Relevance**: The extent to which the HBF aligns with Tanzania's health sector priorities, particularly the focus on PHC and UHC.
- **Effectiveness**: The degree to which HBF-supported interventions are achieving intended results in strengthening PHC service delivery.
- **Efficiency**: How well financial and administrative resources are utilized to generate measurable health outputs and outcomes.
- **Equity** *(context-specific emphasis)*: The extent to which HBF contributes to fair and inclusive access to health services across geographic regions and vulnerable populations.
- **Coherence**: The degree of alignment and integration between HBF and other public and donor-supported financing mechanisms in the health sector.
- **Sustainability**: The likelihood that the benefits, systems, and institutional reforms supported by the HBF will be maintained over time, including in the context of ongoing UHC reforms.

These criteria structured both the design of data collection tools and the analysis framework for this report. Data collection and analysis were guided by the following conceptual framework **(Figure 1).** The figure highlights the connections between financing mechanisms, objectives (relevance, coherence, effectiveness, efficiency, and impact), and broader health system outcomes (such as improved access to care, financial protection, equity, and responsiveness).

Figure 1: Conceptual Framework


Health system functions
Health system goals
Resource Generation
Objectives of health financing
Service Delivery
Financing Mechanisms
Health Basket Fund
Health Insurance
Block Grant
Own Sources
Other Financing
• World Bank
• Results financing
• UNICEF / WHO
• etc
Relevance
Effectiveness
Coherence
Efficiency
Transparency
Health gain
Access
Quality
Equity in health
Financial protection
Equity of finance
Responsiveness
Stewardship/governance

2.2 Study design

A cross-sectional analytical mixed methods study (desk review of existing documents, secondary data analysis of information extracted from government information systems, key informant interviews – KIIs, focus group discussions – FGDs, Group Discussion - GD) was used. The MTR team reviewed and analyzed financial and service delivery data covering fiscal years 2020/21 to 2023/24.

2.3 Qualitative Data

2.3.1 Study area and population

The study involved interviews with key informants/stakeholders at national and sub-national level who are involved in the planning, budgeting, execution and evaluation of the health sector budget.

At the **national level**, KIIs were conducted with government representatives, HBF partners and development partners not contributing to the HBF.

At the **sub-national level**, key informants included beneficiaries, members of Health Facility Governing Committee (HFGCs), health facility staff, District Medical Officers (DMOs), Council Health Management Teams (CHMTs), Council Health Service Boards (CHSBs), Regional Medical Officers (RMOs), Regional Health Management Teams (RHMTs), representatives from the private sector and Non-State Actors for Health (NSA-H) as well as civil society organizations.

2.3.2 Sampling

The consultants applied a purposive sampling based on the recommendations of the Basket Financing Committee (BFC), especially of the Director of Policy and Planning (DPP) MoH who chairs both the Performance Monitoring Sub-Committee (PMSC) and the Audit and Finance Sub-Committee (AFSC). Further, recommendations from Development Partners contributing to the HBF were considered for the sampling of KIIs.

At national level stakeholders from the Government of Tanzania (GoT), Development Partners (DPs), both contributing and non-contributing to the health basket fund, and technical agencies were identified for conducting key-informant interviews (Table 1). This approach ensured representation of different perspectives that added value to the study objectives.

At sub-national level the study was conducted in Tanzania mainland covering at least one region from each of the 8 zones used by the GoT (Table 1). Two councils (rural and urban) were selected from each of the sampled regions, making a total of 16 councils. Selection of LGAs was based on the scores of the HBF indicators. The scores were grouped into high (LGA score 80≥), medium (LGA score 80> and ≥ 60) and the lowest score (LGA score 60 <). The selected LGAs are equally distributed in urban and rural areas except the Dar es Salaam region of which all its LGAs are in urban settings. Two additional councils (Buchosa and Ileje District) were selected, to reach a sample representing 10% of the 184 councils. The basis for selection of these two additional councils was based on the criteria of fair representation for the 16 councils at different levels, such as rural and urban councils, rural and urban hospitals, and others, and fill eventual gaps through these two additional councils. In each council a district hospital, a health centre and a dispensary were selected and visited.

Table 1: Sampling: Selection of Regions, Councils and Healthcare Facilities

Zone	Region	Council	Locality	Performance Score	Hospital	Health Centre	Dispensary
Eastern	Dar es Salaam	Ilala CC	Urban	High	Kivule Hospita	Pugu Kajiungeni	Gerezani
		Ubungo MC	Urban	Medium	Ubungo District	Kimara	Mpiji Magoe
Northern	Arusha	Arusha CC	Urban	Medium	Arusha City	Kaloleni	Nadosoito
		Meru DC	Rural	Medium	Meru District	Usa River	Maji ya Chai
Lake	Mwanza	Nyamagana (Mwanza City)	Urban	High	Nyamagana District	Makongoro	Buhongwa
		Ukerewe DC	Rural	Low	Nansio District	Kanguguli	Namagondo
		Buchosa DC	Rural	Low	Buchosa District Hospital	Nyehunge	Sukuma
Western	Kigoma	Kigoma/Ujiji MC	Urban	Medium	Ujiji Health Center	Gungu	Msufini
		Kasulu DC	Rural	Medium	Kasulu District	Kimwanya	Rungwe Mpya
Central	Dodoma	Dodoma CC	Urban	High	St.Gemma	Makole HC	Nghonghonha
		Bahi DC	Rural	Medium	Bahi Distric	Mundemu	Chonde
South West	Katavi	Mpanda MC	Urban	Medium	Mpanda District	Ilembo	Milala
		Nsimbo DC	Rural	Medium	Nsimbo District	Katumba/8	Mtapenda
Southern Highlands	Iringa	Iringa MC	Urban	High	Iringa District	Ipogoro	Nduli
		Mufindi DC	Rural	Medium	Mufindi District	Kasanga	Chogo
Southern	Mtwara	Masasi TC	Urban	High	Mkomaindo District	Mtandi	Makulani
		Nanyumbu DC	Rural	Medium	Mangaka District	Mtambaswala	Masuguru

	Songwe	Ileje DC	Rural	Low	Ileje District hospital	Lubanda	Ngulugulu

Note: CC City Council, DC – District Council, MC – Municipal Council, and TC – Town Council

2.3.3 Data Collection

KIIs were conducted at the national and sub-national level. Semi-structured interview guides were used and information covered included experience in the HBF in terms of its relevance, effectiveness, coherence, efficiency, sustainability and impact. Information covered included community involvement in the development of healthcare plans, budgeting and execution of budgets at the facilities, and the perception of the role of the HBF within the complex funding mechanisms applied at health facility level, with their respective requirements and management challenges. The number of respondents is indicated in Table 2 below. Focus group discussions were mainly conducted with RHMTs & CHMTs.

Table 2: KII, GDs and FGDs conducted

Category	**FGD**		**GD**	**KII**				
MoH, MoF, PORALG & NHIF	-		-	9				
DPs - HBF			3	6				
Health Financing experts				4				
Sub-total			3	19				
	Regional	Council		Regional	Council	Hospital	HC	Dispensary
Arusha	1	2		1	7	1	5	5
Dar es Salaam	1	2		0	2	2	4	3
Dodoma	0	1		0	2	5	4	4
Iringa	1	2		1	3	3	3	3
Katavi	0	2		1	2	3	4	3
Kigoma	1	2		1	2	4	4	4
Mwanza	1	3		1	3	6	6	6
Songwe	1	1		1	2	1	2	2
Mtwara	1	2		1	3	1	2	3
Sub-total	7	17		7	26	26	34	33
Total	**24**		**3**	**145**				

Note: HC – Health Centre; GD – group discussion where 2 – 3 respondents participated in the interview from the same institution.

Informed consent was obtained from all those participating in the KIIs, FGDs or GD, as well as all other individuals providing information for the research. All participants were informed about the objectives of the research and that they are free to choose to participate or not, with no adverse consequences arising from their decision.

2.3.4 Summary of Qualitative Data Sources and Collection

Key Informant Interviews

The nationwide qualitative field study formed the core of the primary data collection. The MTR team conducted over **160 semi-structured interviews** across multiple health system levels, including:

- 15 national-level stakeholders, including the MoH, PO-RALG, MoF, and DPs (both contributing and non-contributing to the HBF).
- 9 regions and 18 councils were selected to ensure geographic diversity and representativeness.
- 36 health facilities, consisting of:
- 9 hospitals
- 9 health centres
- 18 dispensaries

Interviewees included:

- Senior government officials and technical advisors
- Development Partner representatives
- Regional and Council Health Management Teams
- Health facility managers and staff
- Members of Health Facility Governing Committees
- Members of Council Health Service Boards

The sampling approach ensured inclusion of urban, rural, well-performing, and under-resourced contexts.

2.4 Quantitative Data and Budget Analysis

The MTR team reviewed and analyzed financial and service delivery data covering fiscal years **2020/21** to **2023/24**, including:

- HBF disbursement and utilization data at national and facility levels
- Allocation formula parameters and trends
- Health budget execution reports and planning guidelines
- Facility-level budget allocations, with a focus on medicines, outreach, and operational support
- Integration of insurance reimbursements and other local funding sources

Quantitative findings were triangulated with qualitative interview insights and document review findings.

Data Extraction from government information systems

Data extraction was conducted using official government information systems, including the District Health Information System 2 (DHIS-2)/ HMIS, FFARS, Integrated Financial Management Information System (IFMIS), the GoT accounting system "Mfumo wa Ulipaji Serikalini" (MUSE), the "Government of Tanzania - Hospital Management Information System" (GoT-HoMIS), and the GoT Planning and Reporting tool PlanRep. A tailored data extraction tool was developed and employed to retrieve pertinent information related to the HBF from these sources. A data extraction tool was prepared and used to extract any potential information linked to the HBF from the documents.

2.5 Document and Policy Review

An in-depth review of more than 50 documents was undertaken, covering:

- National policy frameworks and strategic documents (e.g., HSSP V, PHC and UHC strategies)
- Health financing and budgeting guidelines
- HBF operations manuals and evaluation reports
- Development Partner reports, Joint Health Sector Review (JHSR) proceedings, and vertical program documentation
- Drafts and laws relating to the implementation of the UHI

This review helped track the evolution of the HBF, identify structural and policy bottlenecks, and verify the consistency of its operation with national and international best practices.

2.5.1 Collecting relevant documents

Key documents were collected that relate to the operationalization of the HBF at the national and sub-national level. The documents include: the Memorandum of Understanding (2021-2025), the MOH and PORALG's MTEFs for FY 2020/21- 2022/23, summaries of Council Comprehensive Health Plans (URT, 2020a), including facility plans and implementation reports for FY 2020/21 to 2022/2023, quarterly and annual Income and Expenditures Reports to LGAs through the use of MUSE and FFARS, MOH, Side Agreements for FY 2020/21, 2021/2022 and 2022/23, Internal Auditor General reports on Independent Verification of Health Service Results Supported by the Health Basket Fund for the period under review, Health Sector Strategic Plan V (2021-2026), National Health Policy 2007, Universal Health Insurance Act of 2023, Tanzania Demographic Health Survey 2022, Service Availability Readiness Assessment, Draft HSSP V MTR Report, Human Resource for Health Tanzania Mainland Country Profile 2023, Primary Healthcare Service Strategy 2022 – 2032, Health SWAp Code of Conduct (2021), Regional Health Planning Guideline (2014), Comprehensive Council Health Plan Guidelines (2020), Health Facility Planning Guidelines, GoT Financial Regulations & Local Government Financial Act & Regulations, HBF MTR Reports, 2021, Health Sector Performance Profile Reports, MOH and PORALG Strategic Plans.

In addition, the review was extended to any public report and peer reviewed published work done in Tanzania related to the HBF and impact on service delivery (please see Annex 2).

2.5.2 Data analysis

Qualitative

A codebook was developed inductively and deductively and discussed in the process of developing main themes and subthemes (Kason & Kevin, 2023). Interviews done in Swahili language were fully transcribed and translated into English, and verbatim key quotations were included in the main report. Framework analysis was used for summarizing the data to address the research questions. The NVivo 15.0 (QSR International Pty Ltd) software was deployed for qualitative data analysis. During data analysis, information was triangulated and synthesized.

Quantitative

Descriptive analysis was performed on the extracted secondary data, focusing on the proportion of the HBF allocated to councils and service delivery indicators from the DHIS-2 for the Financial Year 2020/21 to December 2023. Descriptive statistics, including measures such as mean and median, were utilized to summarize the data. The findings are presented as means, rates, and proportions, displayed through tables and figures. The analysis was conducted using Microsoft Excel and Stata version 16.

Desk/document review

Documents were reviewed and analysed with a particular focus on the effectiveness of the HBF regarding health outcomes as proposed within the HSSP V, as well as equity and participation of the citizens in the oversight of planning and budgeting for primary health care services. Relevant aspects identified were summarized and triangulated with quantitative data.

2.6 Use of Software and Data Management

To ensure methodological rigor and analytical depth, the MTR team employed a suite of licensed software platforms throughout the process:

- **ODK (Open Data Kit)** for field-based digital data collection, enabling real-time syncing, GPS tracking, and efficient data validation during interviews.
- **Sonix AI**, a secure transcription and translation tool, was used to process over 160 audio recordings from interviews, significantly expediting transcription while maintaining data integrity and linguistic accuracy.
- **NVivo15** supported systematic coding and qualitative analysis, allowing for the identification of recurring themes and patterns across stakeholder levels and geographic regions.
- **ChatGPT Team**, a secure AI-assisted analysis tool, was used selectively to support synthesis of findings, improve drafting clarity, and ensure consistent terminology. All inputs were anonymized, with no personal or confidential data shared, and use was fully compliant with data protection protocols.
- **Microsoft Excel, Word, and Stata** were used for data cleaning, statistical analysis, visualization, and drafting of financial and narrative sections of the report.

All tools were used in compliance with institutional data protection protocols, and only licensed versions were applied to ensure secure handling of sensitive information. This included full adherence to strict confidentiality and ethical standards for every platform listed above. Measures applied uniformly across tools included:

- **Anonymization** of respondent data during transcription and analysis;
- **Secure encrypted storage** of audio recordings, transcripts, and digital files;
- **Informed consent procedures** for all interview participants.

The MTR team followed the ethical and quality assurance provisions outlined in the Inception Report, including internal peer review and adherence to international research standards.

2.7 Limitations and Mitigation Measures

The MTR faced the following limitations and applied mitigation measures:

Limitation	**Mitigation**
Variability in data availability across councils and facilities	Used national datasets and triangulated findings with interview responses and financial data from fieldwork
Incomplete disaggregated performance data at facility level	Supplemented gaps with insights from facility managers and supervision reports
Interview fatigue or reluctance due to prior assessments in some councils	Ensured streamlined interviews, guaranteed anonymity, and minimized duplication of previous assessment topics
Changes in government staff and evolving nature of UHI reform	Maintained regular consultation with MoH, PO-RALG, and HBF Secretariat to validate findings and incorporate latest updates

Despite these challenges, the multi-source, multi-level methodology yielded robust and actionable findings, ensuring that the final analysis is grounded in diverse perspectives and evidence.

3. EMPIRICAL FINDINGS: PERFORMANCE OF THE HEALTH BASKET FUND (HBF)

This chapter presents the full empirical findings of the MTR of the HBF, based on triangulated evidence from qualitative interviews, quantitative financial and performance data, and an extensive review of policy and planning documents. The analysis is structured along ten key thematic areas that reflect the core functions, mechanisms, and operational environment of the HBF. Each section synthesizes evidence from multiple levels of the health system-national, regional, district, and facility-and integrates the perspectives of diverse stakeholders, including government officials, health workers, community representatives, and development partners. While the findings cover a broad scope, they focus on assessing the actual functioning of the HBF in practice and its contributions to PHC delivery in Tanzania. This evidence base directly informs the synthesis of key strategic issues presented in Chapter 4.

3.1 Governance and Institutional Architecture

This section reviews the governance structure and institutional arrangements that guide the HBF in Tanzania. The analysis draws on policy documents, the current HBF MoU (2021–2026), technical guidelines, and perspectives gathered through KIIs, FGDs and GDs conducted during the MTR.

3.1.1 Evolution of the HBF Governance Framework

The Health Basket Fund has served as a central pooled financing mechanism for Tanzania's health sector for over two decades. Originally introduced to harmonize DPs support with national health strategies, the HBF is today governed through a formal MoU, renewed in its current version for the 2021–2026 period.

The MoU outlines shared responsibilities between the GoT and contributing DPs. Signatory DPs currently include the Embassy of Switzerland, Korea International Cooperation Agency (KOICA), Danish International Development Agency (DANIDA), United Nations Children's Fund (UNICEF), Ireland, Global Affairs Canada, and United Nations Population Fund (UNFPA). DANIDA was expected to exit by the end of FY 2022/23 but has continued to contribute under the DANIDA Investment Facility. The World Bank, as the long-term development partner, formally began its participation under the current MoU in the 2023/2024 financial year, followed by the UK's Foreign, Commonwealth, and Development Office (FCDO) in FY 2024/25.

3.1.2 Institutional Responsibilities and Coordination Structures

HBF implementation and oversight are structured across four core tiers:

- **MoH:** Provides strategic direction, technical oversight, and ensures alignment with national health policy, including the Health Sector Strategic Plan (HSSP V).
- **PO-RALG:** Coordinates disbursement and supervision at the LGA level and supports implementation of the DHFF framework.
- **MoF:** Oversees financial releases through the Exchequer system and participates in broader budget negotiations for the health sector.
- **DPs:** Contribute funds to the pooled mechanism and engage in regular reviews and dialogue forums.

Implementation and governance are supported through five main coordination platforms:

1. **The Basket Financing Committee (BFC)**, made up of representatives from each signatory, administer the MoU. Amendments to the MoU or its attachments require BFC approval. The BFC provides oversight and guidance to the HBF, annually agreeing on a Side Agreement that outlines commitments and budget allocations, and approving disbursements to and from the USD Holding Account for HBF recipients as specified in the Side Agreement.

2. **Performance Monitoring Sub-Committee (PMSC)**: The PMSC evaluates performance indicators related to service delivery, resource utilization, and quality of care within HBF-funded facilities. It holds health facilities accountable for the effective use of funds and produces reports on their performance to support decision-making and enhance the HBF system.

3. **Audit and Finance Sub-Committee (AFSC)**: AFSC oversees the financial and operational performance of the HBF, ensuring transparency, accountability, and efficient resource utilization. The AFSC reviews financial statements, operational processes, procurement protocols, fund disbursement practices, and reporting mechanisms. It identifies and evaluates financial and operational risks, developing strategies to mitigate them. The committee assesses internal control systems to safeguard assets and prevent fraud or error, supervises audit activities, and ensures compliance with laws, regulations, and donor stipulations.

4. **Health Sector Working Group (HSWG):** Provides a broader coordination forum for all health sector stakeholders under the lead of MoH.

5. **Joint Annual Health Sector Reviews (JAHSR):** Facilitates high-level review of sector progress and HBF contributions.

"…*The HBF setup allows Development Partners to engage in a structured and coordinated way. However, there is a strong dependency on certain procedural steps - like the IAG report - that can slow things down*…." (KII, DP Representative, Field Interview).

3.1.3 Fund Flow Mechanisms and Planning Alignment

The HBF follows the Government's Exchequer system, hence the funds from the HBF holding account are transferred directly to the bank accounts of PHC facilities. Budgeting is conducted using PlanRep during the annual CCHP process.

Planning and disbursement are aligned to the fiscal year but often face delays due to procedural dependencies. One key bottleneck identified during the MTR is the link between the Internal Auditor General's (IAG) performance report and the timing of HBF disbursements.

> "*Every year we are late with starting activities because we wait for the IAG report and side agreements to be signed*." (CHMT Member, Field Interview)

3.1.4 Performance Monitoring and Result-Based Allocation

Since the 2016–2020 HBF cycle, the Fund has partially transitioned from input-based to results-based allocation. Under the current MoU, disbursements are linked to performance indicators tracked at facility, council, and regional levels. These include service coverage indicators, such as reproductive, maternal, newborn, and child health (antenatal care visits, nutrition, labour & delivery, family planning); communicable and non-communicable disease; health commodities and structural readiness parameters. MTR for the National Plan for Reproductive, Maternal, Newborn, Child, and Adolescent Health & Nutrition showed that only 11% of dispensaries and 32% of health centres and district hospitals provide all the required services during a standard visit. Urban-rural disparities persist, with fewer rural facilities equipped with essential ANC items

such as hemoglobin tests and urine dipsticks (MoHCDGEC, 2021; URT, 2021e; Mtenga et al., 2025).

The HBF Scorecard summarizes LGA-level results and guides the performance-based allocation formula.

> "*The performance system is good, but some indicators don't reflect our realities - we don't do C-sections at dispensary level, yet it affects our scores*." (Facility In-Charge, Dispensary, Field Interview).

3.1.5 Challenges in Governance Implementation

The MTR identified the following challenges related to governance:

- **Procedural Delays:** The dependency of fund release on annual IAG audits and side agreement signings causes implementation delays across all LGAs.
- **Role Clarity:** While the division of roles between MoH, PO-RALG, and LGAs is generally well understood, overlapping responsibilities in supervision and reporting sometimes create duplication and inefficiencies.
- **Partner Transitions and Communication:** Changes in DP contributions (e.g. entry of new DPs, exit or reduced disbursement by others) require continuous renegotiation and adjustment of MoU expectations.

Interview responses from CHMT and RHMT members underscored operational tensions between the policy intent of decentralization and the reality of uneven implementation capacity. While DHFF has formally devolved authority to facility level, CHMTs reported being forced to step in frequently to correct or adjust facility budgets, due to capacity limitations at the frontline. RHMTs, in turn, highlighted weak upward or horizontal accountability mechanisms to support learning and supervision across councils.

> *"We are expected to oversee without authority. If a facility underperforms, we have no leverage."* (RHMT Member, Southern Highlands Zone, Field Interview).

These coordination gaps contribute to inefficiencies and frustration across governance levels. CHMTs in several councils suggested that while DHFF increases autonomy in theory, the absence of continuous mentorship and a clear escalation framework often leaves facility in-charges without adequate support, and councils without tools to intervene appropriately.

3.1.6 Governance Strengths and Opportunities

Despite its challenges, the HBF is widely perceived as a well-functioning pooled funding mechanism, and a platform that ensures government leadership in a context of development partner coordination.

Key strengths include:

- Long-term institutional memory and experience with pooled funding
- Integration of DP funds into government systems and planning processes
- Alignment with national health priorities, including PHC and UHC objectives

Opportunities exist to improve the efficiency of the governance framework through:

- Earlier agreement on IAG Terms of Reference and timelines
- Clarified reallocation guidelines to enhance facility-level responsiveness

- Greater use of digital monitoring platforms to track fund utilization and performance metrics

Development Partners praised the overall design of the HBF as an aligned financing mechanism supporting PHC, but expressed concern over the declining role of the HBF Steering Committee and weakening of structured dialogue. Several partners emphasized the need to re-establish a high-level coordination forum, enabling policy engagement beyond disbursement monitoring.

> *"Governance exists on paper, but the political weight behind the basket has declined."* (KII, DP, representative 4).

> *"We need a platform to talk policy, not just finance."* (KII, DP, representative 3, Field Interview).

3.2 Financial Contributions and Disbursement Trends

This section analyzes the volume, trends, and composition of funding through the HBF, including contributions from DPs, disbursement patterns over time, and how these resources complement government allocations to the health sector. It integrates data from financial reports, budget documents, FFARS, and Development Partner records, as well as key insights from stakeholder interviews.

3.2.1 Overview of HBF Composition

The HBF has mobilized substantial DPs resources to support Tanzania's PHC system. The funding is pooled and disbursed via the national Exchequer system, with contributions from bilateral and multilateral partners.

The main contributors during the review period (FY 2020/21 to FY 2022/23) include the Swiss Development Cooperation, KOICA, DANIDA, UNICEF, Ireland, UNFPA, Global Affairs Canada, and the World Bank. DANIDA officially exited the HBF by the end of FY 2022/23 but contributed through an investment modality in FY 2023/24. The World Bank and FCDO joined more recently, with disbursements beginning in FY 2023/24 and FY 2024/25, respectively.

3.2.2 Development of Funding Commitments

Overall, there is an increase in funding committed within the side agreements from 2021/22 to 2024/25, rising from US$ 19.73 million to US$ 59.93 million (URT, 2021c; URT, 2022b; URT, 2023g; URT, 2024a; URT, 2019a). During the signing of the annual side agreement for the fiscal year 2021/22 DPs committed US$ 19.7255 million (46.398 billion TZS) while in 2022/23, the DPs pledged a total of US$ 42.2 million (approximately TZS 98 billion) to facilitate the implementation of central, regional, and health facility plans.

). For the fiscal year 2023/24, DPs committed financial support of US$ 54,104,568.30 (approximately TZS 126 billion). Additionally, for 2024/25, a total of US$ 59,925,009.03 (approximately TZS 153 billion TZS) is pledged to the health sector through HBF. However, when examining the contributions of each DPs to the pool, we can see a consistent support of long-term DPs like Canada, Ireland, and Switzerland (**Table 3,** Figure 2). For example, contributions from Canada have remained steady despite fluctuations due to currency exchange rates from 2022/23 to 2024/25. The World Bank as a long-term development partner under the current MoU, beginning in the 2023/2024 financial year, has significantly altered funding percentages.

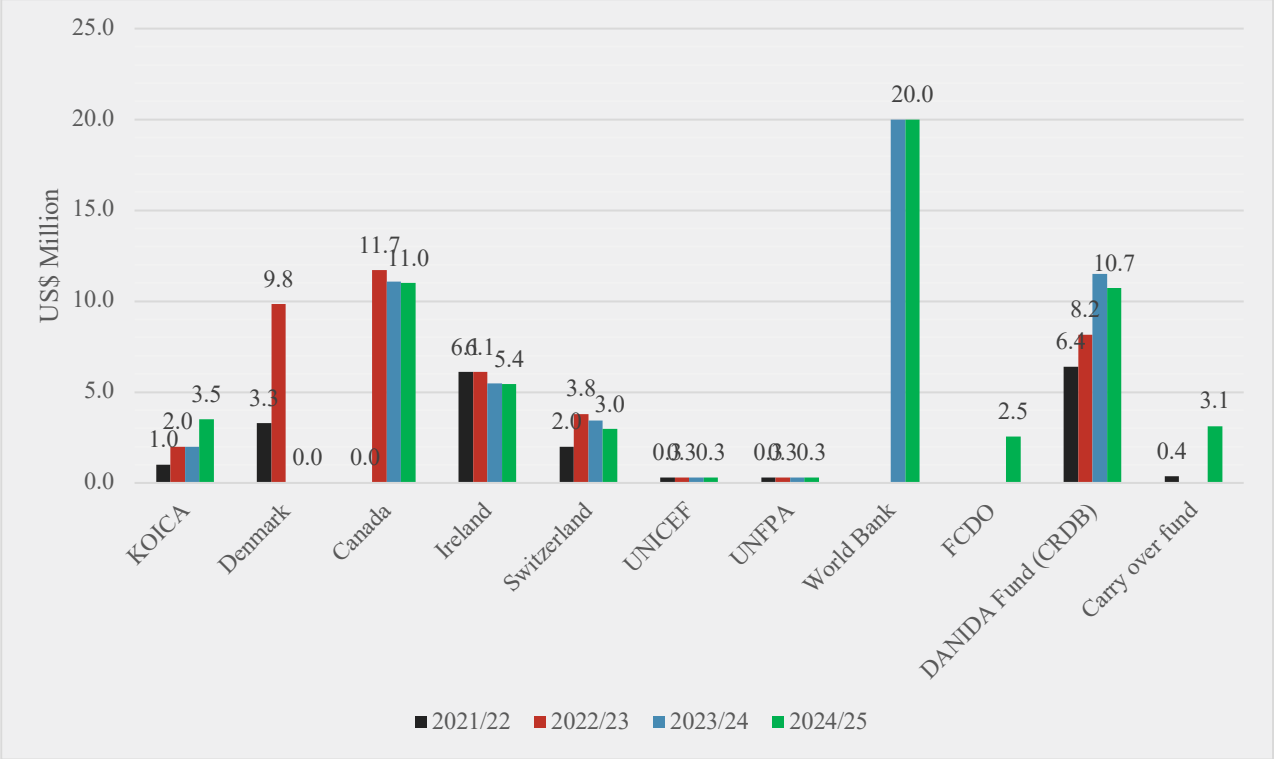
Table 3: Basket Partners Committed Financial Support 2021/22 – 2024/25

Partners	2021/22			2022/23			2023/24			2024/25		
	$ million	TZS (Billion)	%	$ million	TZS (Billion)	%	$ million	TZS (Billion)	%	$ million	TZS (Billion)	%
KOICA	1.00	2.35	5	2.00	4.65	5	2.00	4.69	4	3.50	8.94	6
Denmark	3.28	7.72	17	9.84	22.90	23	-	-	-	-	-	-
Canada	-	-	0	11.70	27.22	28	11.08	25.98	20	11.01	28.13	18
Ireland	6.10	14.35	31	6.10	14.19	14	5.49	12.88	10	5.44	13.89	9
Switzerland	2.00	4.70	10	3.80	8.84	9	3.42	8.02	6	2.98	7.61	5
UNICEF	0.30	0.71	2	0.30	0.70	1	0.30	0.70	1	0.30	0.77	1
UNFPA	0.30	0.71	2	0.30	0.70	1	0.30	0.70	1	0.30	0.77	1
World Bank	-	-	-	-	-	-	20.00	46.90	37	20.00	51.10	33
FCDO	-	-	-	-	-	-	-	-	-	2.54	6.49	4
DANIDA Fund (CRDB)	6.38	15.00	3	8.17	19.00	19	11.51	27.00	21	10.73	27.40	18
Carry over fund	0.37	0.86	2	-	-	-	-	-	-	3.13	8.01	5
Total	**19.73**	**46.40**	**100**	**42.21**	**98.19**	**100**	**54.10**	**126.88**	**100**	**59.93**	**153.11**	**100**

Note: $ - United States Dollar (US $). The exchange rates per US$1 for 2021/22, 2022/23, 2023/24, and 2024/25 were TZS 2,352.1, TZS 2,326.1, TZS 2,345.1, and TZS 2,555, respectively.

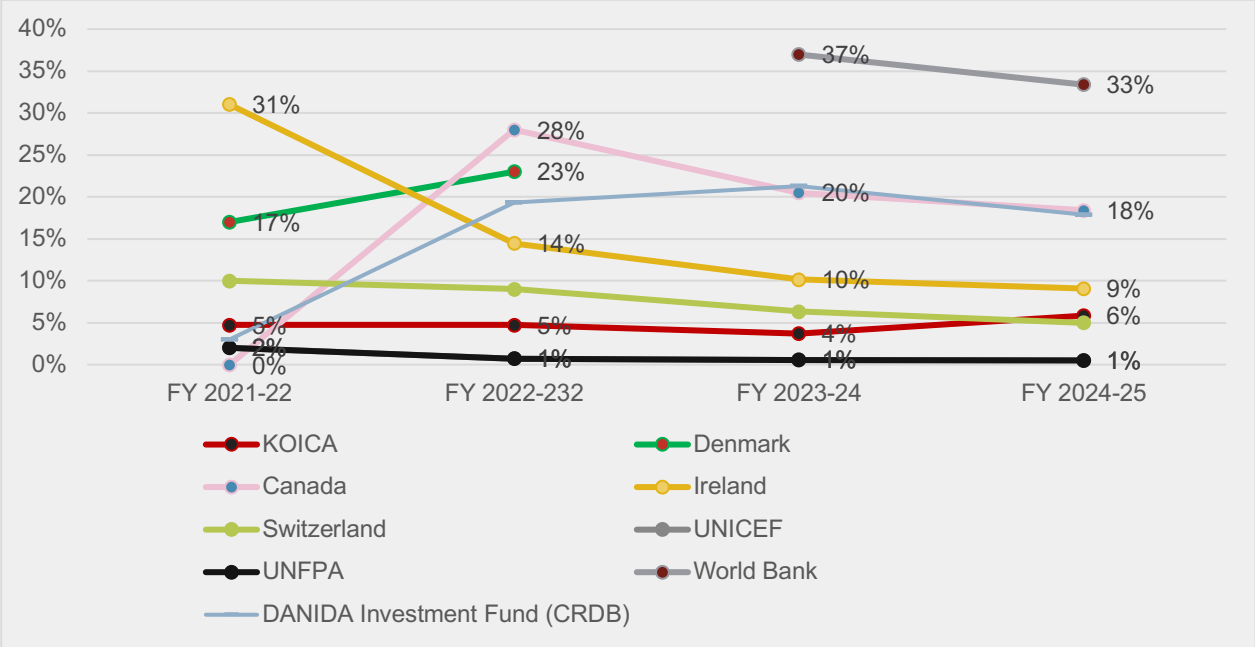
Source: Side Agreement between the GoT and HBF Partners, FY 2022/23; 2023/24; & 2024/25

Figure 2: Health Basket Fund Partner Support 2021/22 - 2024/25 in USD, million



Source: Side Agreement between the GoT and HBF Partners, FY 2021/22; & 2023/24

Figure 3: Proportion of Basket Partners Committed Financial Support 2021/22 – 2024/25



Source: Side Agreement between the GoT and HBF, FY 2022/23; & 2023/24.

Several DPs noted internal constraints such as shifting global priorities or fiscal tightening in donor countries as factors behind reduced commitments. However, others attributed funding volatility to lack of visibility on results, coordination fatigue, and a perceived weakening of joint ownership.

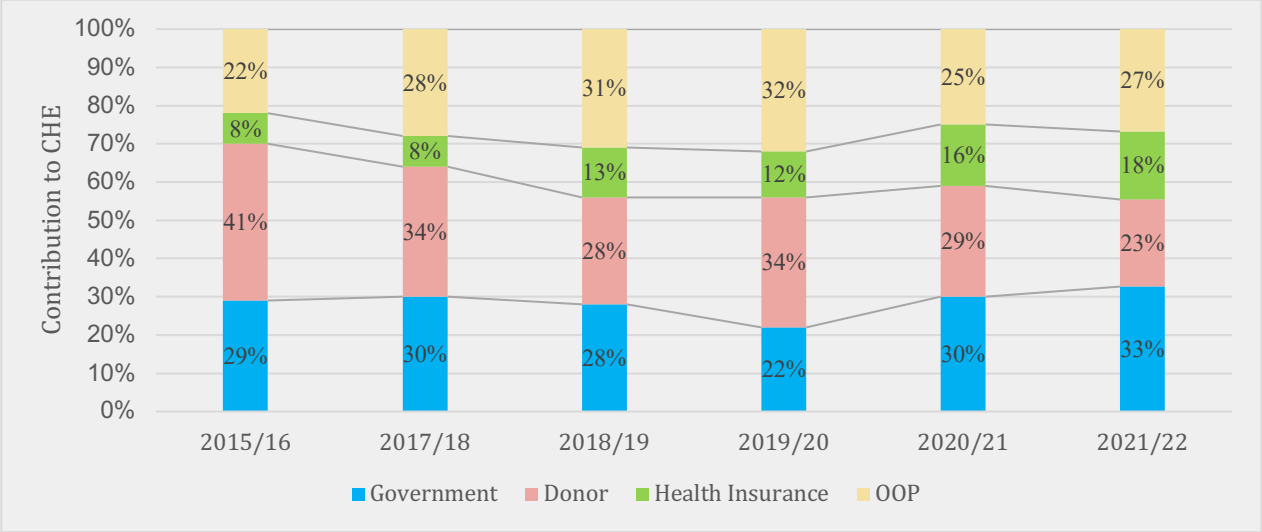
> *"We need evidence that our funds are used strategically. Otherwise, our headquarters ask: why this mechanism?"* (KII, DP, representative 1, Field Interview).
>
> *"There is no current 'story' of the HBF that mobilizes political support on our side."* (KII, DP, representative 2, Field Interview).

3.2.3 Trends in the Composition of Funding Sources for Current Health Expenditure

Looking at the period from 2015/16 to 2021/22, we observe a noticeable decrease in donor funding for Current Health Expenditure (CHE) in Tanzania. Over the course of three financial years (2019/20, 2020/21, and 2021/22), the government's contribution to the health sector has shown a consistent upward trend (URT, 2023b; URT, 2023f). In financial year 2021/22, government funding increased by 11 percent points (ppt) from 22% in 2019/20 to 33% (Figure 4). In contrast, donor contributions during the same period decreased by the same proportion (11 ppt) from 34% in 2019/20 to 23% in 2021/22. Additionally, the proportion of health insurance within total expenditure increased to 18%.

These figures show the commendable increase in domestic funding for Current Health Expenditures and the corresponding decrease on the reliance of foreign funding: domestic contributions in the meanwhile constitute three-quarters of current health expenditure, with foreign spending gradually reducing their share from 41% to about one-quarter of total current health expenditure. Nevertheless, out-of-pocket expenses remain significant, accounting for 27% of total health expenditure. Here the big challenge for the new Universal Health Insurance scheme will be to provide coverage in a way that reduces OOP substantially, especially for the poorer segments of the population.

Figure 4: Trends in the Composition of Funding Sources for Current Health Expenditure



Source: URT (2023b). United Republic of Tanzania. National Health Accounts for Financial Years 2020/21 & 2021/22. Dodoma, Tanzania.[1]

3.2.4 Disbursement Patterns and Trends

HBF funds are released to sectoral ministries and LGAs in quarterly tranches. The Ministry of Finance and Planning manages the disbursement process following verification of disbursement conditions outlined in the Joint Financing Arrangement and side agreements.

However, delays in disbursement have been observed in every fiscal year reviewed. A key factor behind the delays is the procedural link between the IAG performance report and the signing of new side agreements. Development Partners that follow results-based disbursement principles release funds only after receiving and approving the IAG report. This procedural chain often results in disbursement delays of several months.

This problem is compounded by the fact that some DPs wait to sign side agreements only after the report is finalized and reviewed. The resulting delays affect operational planning and service continuity at the council and facility level. CHMTs and health facility in-charges expressed concern that these delays misalign HBF funds with their quarterly work plans, forcing them to defer planned activities.

> "*We prepare plans assuming that funds will arrive on time, but we often wait until the third or fourth month before anything is disbursed. This affects service delivery*." (CHMT member, Central Zone, Field Interview).

Stakeholder interviews indicated that while donor contributions are generally predictable, administrative and procedural requirements (e.g., timely audits and side agreement renewals) sometimes delay actual disbursements.

> "*Sometimes the funds are there, but the procedures delay their release. This affects our ability to plan effectively*." (LGA Accountant, Field Interview).

[1] Figure 3: Donor contribution to CHE include all the funding flowing to the government of Tanzania not only the HBF

Carryovers

At the end of a financial year some funds remain within the facility bank accounts or within the Ministry of Finance – holding accounts for the basket funds. The use of these funds is subject to approval from higher authorities due to government laws and regulations.

> "….. *Carryover funds are funds that are not utilised for the fiscal year and are then carried over to the next fiscal year. While this practice is allowable, it is something that donors do not particularly favour, as they prefer to see the money exhausted according to the envelope for that fiscal year*……." (DPs, representative 1, Field Interview).

> "…. *At the end of the financial year, some funds remain in the facility bank accounts or in the Ministry of Finance holding accounts for the basket funds. The use of these funds is subject to government laws and regulations*……." (MoH representative 1, Field Interview).

> "….. *There are some facilities where, when reviewing financial positions form FARRS, you may find a significant amount of carryover funds. We are concerned about the carryover funds because a large amount indicates that the planned activities are not aligned with the priorities of the communities. By not implementing those activities, the communities' right to receive timely services is compromised. Therefore, we are also dissatisfied with this situation*. ……." (PO-RALG representative 1, Field Interview).

> "…… *According to the budget guidelines outlined in the Budget Act of 2015, once you have a carryover fund, you must notify the Ministry for Finance that you will not be able to spend these funds until at least June 30th. You should also list the activities associated with the carryover. The Budget Act allows you three months to ensure that all funds are spent as specified in the budget*. ……." (PO-RALG representative 2, Field Interview).

Experts noted that beyond technical delays, the underlying cause of irregular disbursements is the predictability of DP contributions and GoT liquidity. They highlighted the lack of a reserve mechanism or contingency plan in DHFF design, meaning any disruption at the treasury level quickly cascades down to facilities.

> *"When a donor disburses late, the impact is real-time at the dispensary."* (Health financing expert, Field Interview).

> *"The design assumed fiscal predictability. Tanzania doesn't have that luxury."* (Health financing expert, Field Interview).

3.2.5 Budget Execution and Utilization Rates

Despite disbursement delays, budget execution at the LGA level has remained relatively strong. Data from the Facility Financial Accounting and Reporting System (FFARS) indicates that over 90% of funds received by primary-level facilities are typically executed within the financial year. This reflects the absorptive capacity and planning commitment of PHC actors.

However, interviews highlighted some concerns about the pressure to use or carry over funds by year-end, sometimes resulting in low-priority expenditures. Additionally, spending is often skewed towards areas required by rigid expenditure ceilings, especially the 35% earmark for medicines and medical equipment.

> "*Sometimes we have funds left but cannot use them for staff motivation or preventive outreach, because the system won't allow it*." (Health Centre in-charge, Southern Highlands, Field Interview).

3.3 Allocation Mechanisms and Equity Formula

3.3.1 Overview of HBF Allocation Framework

The Health Basket Fund allocation at the LGA level is governed by an equity-based formula designed to promote fair resource distribution. This formula determines how HBF funds are distributed across Tanzania's 184 LGAs and was first introduced in 2004, evolving from a per capita model to a more nuanced, needs-based allocation mechanism. The most recent version of the formula includes the following weights:

- **60%** based on population,
- **20%** based on the length of official medical vehicle routes (proxy for geographic dispersion and transport burden),
- **10%** based on the number of poor individuals,
- **10%** based on under-five mortality (proxy for health needs).

These weights aim to balance factors of demand, geographic access, and health vulnerability, ensuring that LGAs with larger or more dispersed populations and higher poverty or mortality rates receive proportionately greater support. Furthermore, the formula does not consider mobility and service utilization across administrative boundaries. Urban facilities often serve populations from surrounding areas, resulting in funding imbalances.

"The allocation formula is a step in the right direction, but it doesn't yet fully reflect the needs at the facility level-particularly for the most remote areas." (Interview with regional health officer, Central Zone, Field Interview).

3.3.2 Distribution by Beneficiary Level

Most HBF funding is allocated to LGAs, specifically for use by CHMTs, district hospitals, health centres, and dispensaries. The allocation follows an equity-based formula that includes population, poverty levels, morbidity, and remoteness (length of official vehicle routes).

Out of the total HBF funding for FY 2022/23, 90% was directed to the LGA level, with 5% retained by sectoral ministries and 5% used for administrative costs and higher-level oversight. Within LGAs, funding is further divided among cost centres:

- 40% to health centres and dispensaries via DHFF,
- 20% to CHMTs,
- 25% to district hospitals,
- 15% to voluntary hospitals where applicable.

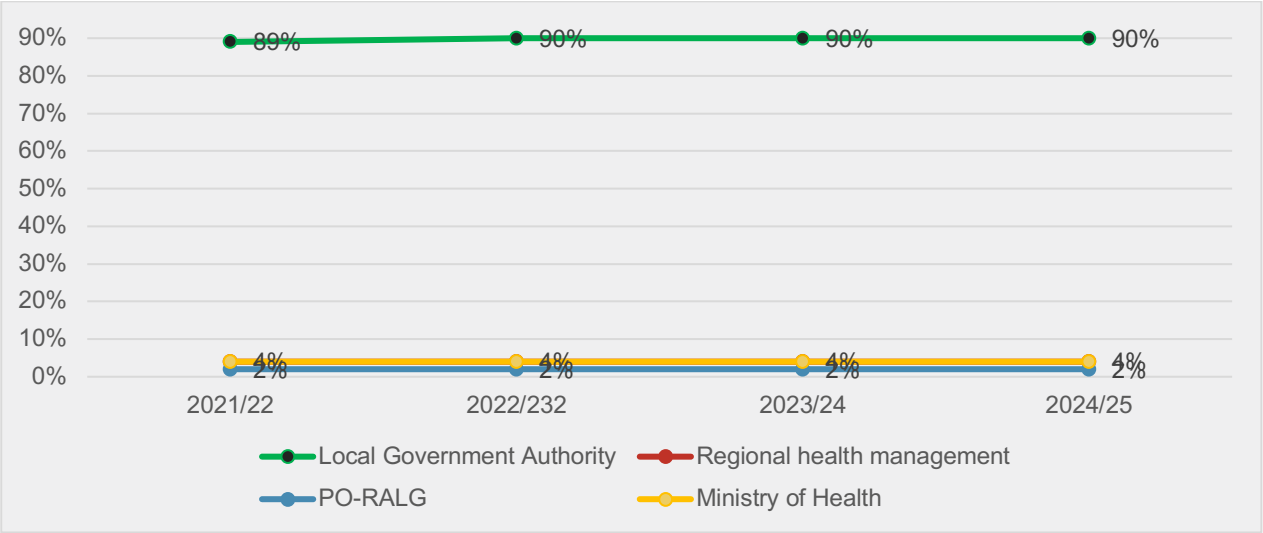
This pattern reflects a strong commitment to decentralization and frontline service delivery, though facilities still face constraints due to inflexible spending rules and inconsistent cash flow.

3.3.3 Allocation of the HBF to recipients

During the three financial years under review, 90% of the total HBF was allocated to LGAs to support service delivery across 6,124 health facilities in all 184 councils (Figure 5). In contrast, 4% was allocated to 26 regional secretariats to enable RHMTs to carry out supportive supervision at the council level. Additionally, 2% was designated for the PO-RALG to facilitate supportive supervision, including backstopping of LGAs' planning processes, as well as the assessment and quality assurance of Comprehensive Council Health Plans, health facility plans, and progress reports, as outlined in the MTEF. Finally, 4% was allocated to the MoH to support the sector's

plans, including the formulation of health policy issues, strategies, and guidelines for the quality assurance of health services within the country.

Figure 5: Allocation of HBF at Various Levels 2021/22 - 2023/24



Sources: Side agreement between the Government of the United Republic of Tanzania and Health Basket Fund Partners, Fiscal Year 2021/22; 2022/23; 2023/24: & 2024/25

Allocation within these cost centres is guided by CCHP guidelines, which are coordinated through the PlanRep system. However, disparities persist at the facility level, particularly affecting remote or under-resourced dispensaries, where allocations do not always match workload or need.

> "*Some dispensaries with high patient volumes and poor infrastructure receive less than better-equipped health centres simply because they can't perform as many reportable procedures*." (Dispensary in-charge, Southern Highlands, Field Interview).

3.3.4 Challenges and Limitations of the Allocation Formula

Despite its equity-oriented design, the current allocation framework exhibits several limitations:

- **Performance Bias:** The formula indirectly favours better-performing health facilities, creating inequities for facilities with structural constraints that hinder their ability to meet performance-based criteria.
- **Static Indicators:** The formula's underlying indicators are infrequently updated and may not reflect rapid demographic or epidemiological shifts, such as internal migration, disease outbreaks, or changes in poverty profiles.
- **Underweighting of Vulnerability:** While poverty and mortality are included, they collectively represent only 20% of the formula, limiting the capacity to target the most underserved populations.
- **Inequities at the Facility Level:** The fund flow mechanisms do not always allow discretionary adjustments at council level, limiting responsiveness to intra-council disparities.

Beyond the structural constraints outlined above, several national-level experts expressed concern that the equity allocation formula, while well-intentioned, is too rigid to account for emerging health system dynamics. In their view, the formula overlooks important contextual factors such as urban poverty pockets, real-time facility workload, cross-boundary service utilization, and vulnerabilities to shocks like disease outbreaks or climate-related disruptions.

While the formula ensures fairness in inputs, it may not translate into fairness in core outcomes without built-in adaptability.

> *"Equity in inputs is not the same as equity in outcomes. That nuance is missing."* (Health Financing Expert, Field Interview).

Field perspectives echoed similar concerns. Several government representatives acknowledged that while some indicators related to reproductive and child health (RCH) have shown success, such as the increased uptake of four or more ANC visits, other indicators remain problematic or outdated.

> *"At the moment, we can say that the indicators are relevant… For example, to measure ANC attendance, mothers who achieve an attendance rate of four or more visits are included. This indicator has already been achieved both regionally and nationally. However, other indicators may be included. In my opinion, they are currently relevant."* (FGD, Southern Zone, Municipal Council).

However, challenges were raised regarding indicators like institutional delivery, which depend on assumptions about patient continuity between ANC and delivery at the same facility. In both Arusha and Iringa regions, respondents noted that women often seek ANC at one location but opt to deliver elsewhere, sometimes in different councils or regions, due to perceived quality, proximity, or personal preference. This creates statistical distortions that penalize facilities despite their efforts.

> *"For example, if Centre A receives fifty ANC clients, it is assigned a target that at least forty-five women will deliver there. However, during the delivery period, all the women may choose to deliver at Centre B… Therefore, it is important to consider additional factors rather than focusing solely on why institutional delivery rates are low at Centre A."* (FGD, Northern Zone, District Council).

> *"Some mothers choose to give birth in other councils… This indicator is what is troubling us. Therefore, I suggest that we consider the number of facility deliveries and the people who attended the clinic."* (FGD, Southern Highlands Zone, Municipal Council).

These findings suggest the need for refining the allocation formula and performance indicators to better reflect service realities, client behavior, and health system capacities at facility level.

3.3.5 Recent Adjustments and Equity Initiatives

In recognition of the limitations described, there have been calls-particularly from Development Partners and local health administrators-for introducing an "equity window" or flexible top-up mechanism. Such a window could allow targeted investments in LGAs or facilities identified as structurally disadvantaged.

Additionally, base allocations per facility (regardless of performance) have been suggested to ensure a minimum level of functioning across the system.

A review of allocation scenarios also revealed that variations in actual funding per capita between LGAs remain considerable, with per capita HBF disbursement ranging from under TZS 5,000 in some rural districts to over TZS 15,000 in better-resourced urban LGAs.

3.4 Disbursement Mechanisms and Timeliness

3.4.1 Overview of Disbursement Modalities

The HBF follows a well-established fund disbursement mechanism that channels Development Partner contributions into the Government of Tanzania's Exchequer System. These funds are subsequently allocated to LGAs based on the agreed equity allocation formula (see Section 3.3) and transferred directly to Council and facility accounts via the FFARS. The system is designed to ensure timely quarterly disbursements aligned with approved Comprehensive Council Health Plans and the national budget cycle.

However, while the disbursement architecture is sound in principle, delays are a recurring challenge in practice. Interviews across the country consistently highlighted disruptions in service delivery caused by lagging fund flows, particularly in Q1 and Q2 of each fiscal year.

> "*The delay in Q1 funds means we begin the financial year with a plan but no budget. Outreach services and medicine purchases are immediately affected*." (FGD, CHMT, Lake Zone).

Across both rural and urban dispensaries, delayed fund disbursements were highlighted as a systemic issue. Facility in-charges commonly reported that disbursements often arrive one to two months into the quarter, disrupting implementation of planned activities. Urban facilities sometimes manage to mitigate delays by drawing on better supplier access or internal credit arrangements. Rural dispensaries, however, face service interruptions and higher costs due to remoteness.

> *"We plan for Q1, but funds come in Q2. By then, priorities have shifted. We just patch holes."* (Facility In-charge, rural dispensary, Central Zone, Field Interview).

Table 4 shows the timeline for the disbursements and fund flow of the HBF in the FY 2023/2024. Significant delays were observed during both the first and last quarters of the fiscal year. For example, during the financial year 2023/2024, donor funds were continuously deposited into the Holding Account at the Bank of Tanzania (BoT). In 2023, funds were transferred in August, October, and November. In 2024, additional funds were transmitted in January, March, and June. In the first quarter, the President's Office - Regional Administration and Local Government (PO-RALG) requested a fund transfer from the Treasury to the LGA and Health Facility (HFS) accounts on September 15, 2023. The health facility received the funds on October 24, 2023. In the fourth quarter, PO-RALG submitted another fund transfer request on March 1, 2024, with the funds arriving at the health facilities on June 3, 2024, just before the end of the Financial Year.

Table 4: Timeline of disbursement and Fund flow of HBF in FY 2023/2024

Location of funds	Action	Responsibility	Date
Donor	Donor funds arrive on Holding Account BoT	World Bank	18/08/2023
		World Bank	22/08/2023
		DANIDA (CRDB)	03/10/2023
		DANIDA (CRDB)	03/10/2023
		SDC	06/10/2023
		IRELAND	01/11/2023
		KOICA	08/11/2023
		UNFPA	04/01/2024
		CANADA	26/01/2024
		UNICEF	08/03/2024

		DANIDA (CRDB)	24/06/2024
QUARTER ONE			
Holding Account	MoH informs PORALG that sufficient funds are on Holding Account for LGA first quarter	MoH	07/09/2023
Holding Account	PO RALG requests transfer of funds from Treasury direct to the LGA and HFS accounts	PORALG	15/09/2023
Health Account no 6	Funds arrive at Health Account no 6	DED	24/10/2023
Health Facility	Funds arrive at HF		24/10/2023
QUARTER TWO			
Holding Account	MoH informs PORALG that sufficient funds are on Holding Account for LGA Second quarter	MoH	11/10/2023
Holding Account	PO RALG requests transfer of funds from Treasury direct to the LGA and HFS accounts	PORALG	13/10/2023
Health Account no 6	Funds arrive at Health Account no 6	DED	15/11/2023
Health Facility	Funds arrive at HF		15/11/2023
QUARTER THREE			
Holding Account	MoH informs PORALG that sufficient funds are on Holding Account for LGA third quarter	MoH	28/11/2023
Holding Account	PO RALG requests transfer of funds from Treasury direct to the LGA and HFS accounts	PORALG	04/12/2023
Health Account no 6	Funds arrive at Health Account no 6	DED	17/01/2024
Health Facility	Funds arrive at HF		17/01/2024
QUARTER FOUR			
Holding Account	MoH informs PORALG that sufficient funds are on Holding Account for LGA fourth quarter	MoH	20/02/2024
Holding Account	PO RALG requests transfer of funds from Treasury direct to the LGA and HFS accounts	PORALG	01/03/2024
Health Account no 6	Funds arrive at Health Account no 6	DED	03/06/2024
Health Facility	Funds arrive at HF		03/06/2024

Source: MoH

3.4.2 Causes of Delays

Disbursement delays are rooted in both administrative bottlenecks and procedural dependencies, including:

- **Dependency on IAG Performance Reports**: The current MoU between the Government and DPs requires the Internal Auditor General to submit a performance report before new side agreements can be signed, which in turn unlock fund releases. In most years, this report is finalized several months after the start of the fiscal year.
- **Side Agreement Negotiations**: Delays in signing bilateral agreements between the Government and individual DPs prolong the disbursement process even after budget approval. This has particularly affected DPs that do not adhere to results-based disbursement conditions.
- **Systemic Cash Flow Constraints**: Treasury-level cash management and prioritization sometimes delay releases even after the MoF has authorized transfers.

Hospital management teams in both rural and urban areas highlighted delays in fund transfers, noting that quarterly disbursements often arrived 4–8 weeks late. This affected procurement cycles and staff incentive payments. Urban hospitals were slightly more buffered through local supplier relationships, while rural hospitals cited cancelled procurements and postponed outreach services.

"*We wait for months. Sometimes medicines are already out of stock and services are suspended. By the time funds arrive, the damage is done*." (Dispensary in-charge, Southern Highlands).

"*Each year it's the same problem: no funds in Q1, then a flood of activity in Q3 to catch up. We need a different way*." (Regional Health Officer, Eastern Zone, Field Interview).

"We end up negotiating with suppliers every month, explaining why payment hasn't come." (Hospital Administrator, urban hospital, Coastal Zone, Field Interview).

"Our maternal outreach to remote wards was suspended for two months due to delayed funds." (In-charge, rural hospital, Western Zone, Field Interview).

CHMTs consistently cited the central approval process and late release of funds as primary bottlenecks. Several districts reported receiving Q3 funds close to the end of the fiscal year. RHMTs expressed concern that delay patterns weaken trust in budgeting, both among implementers and communities.

"Disbursement arrives when implementation windows are closed." (FGD, CHMT, Southern Highlands Zone).

"We plan quarterly, but we execute annually." (RHMT Officer, Western Zone, Field Interview).

3.4.3 Effects on Service Delivery

The consequences of disbursement delays are evident at all levels of the health system, particularly in:

- **Interrupted Planning Cycles**: LGAs often revise their CCHP activity calendars because funds arrive after key implementation windows have passed.
- **Procurement Delays**: Purchase of medicines and medical supplies through the Medical Stores Department (MSD) or the Jazia Prime Vendor system (Jazia PVS) is postponed, leading to stock-outs at facilities.
- **Reduced Outreach Activities**: Community outreach, immunization campaigns, and mobile services are often first to be suspended due to a lack of operational funds early in the fiscal year.
- **Administrative Disruption**: CHMTs and facility in-charges face pressure to fast-track implementation in Q3 and Q4 to meet absorption targets, reducing quality and increasing stress on the workforce.

Health centres across regions reported significant service disruptions resulting from delays in HBF disbursements. These delays not only hinder activity implementation at the council level but also directly impact health facility operations. Rural health centres were particularly affected, citing missed referrals, stock-outs of essential drugs, and postponement of maternal services. Urban centres managed somewhat better due to stronger local procurement networks and support from municipal authorities. In both settings, facility staff frequently resorted to negotiating with suppliers on credit to sustain service delivery. Moreover, delayed fund flow often caused a carry-over of activities into the next fiscal year, disrupting the planned timelines outlined in the CCHPs. Because financial allocations arrive late, quarterly reports—especially for the first and second quarters—may not accurately reflect planned interventions or expenditures at the facility, council, or regional levels.

*"We had to send pregnant women to a private clinic during one quarter – we had no gloves." (*Facility In-charge, rural health centre, Western Zone, Field Interview)

"… *There is something called a quarterly financial report. Every quarter, a report is prepared on the interventions that have been implemented by various healthcare facilities. This process involves a chain of communication starting from the facilities, through the council and regional level all the way to the Ministry. Therefore, monitoring occurs within that chain. You may find yourself with zero in the first quarter, and zero in the second quarter. This is the situation you encounter because the information you report does not reflect unreceived funds*…." (FGD, Coastal Zone Field Interview).

"… *Currently, delays are occurring, and we are no longer receiving funding every quarter as we used to. Instead, we may find that two quarters are combined, or there might be instances when we receive three quarters' worth of funding at the end of the year. The lump-sum approach to fund disbursement creates challenges in accounting for certain activities planned in a fiscal year, forcing us to rush and complete the work of multiple quarters within a single quarter*. …." (FGD, Southern Zone, Field Interview).

Almost all the healthcare facilities visited reported that delays in the disbursement of the HBF affect service provision. For example, planned purchases of healthcare commodities may not proceed as intended, leading to disruptions in healthcare services.

"…*One of the challenges, as I mentioned earlier, is that we have planned tasks or activities that can be difficult to implement in the event of delays. For example, if funds for purchasing medicines through the basket source are delayed, this can hinder timely service provision. To address this challenge, we have decided not to rely solely on one source, such as the basket source. Instead, we have been combining it with other funding sources to ensure that if the basket source is delayed, we still have alternative funding to keep our operations running while we wait for the basket funds*…." (KII, Northern Zone Field Interview).

"… *You have other activities that you are behind in completing, and you may be surprised when the money arrives. You are informed that it will likely come in June, meaning the year is almost over. When the money finally arrives, you rush to spend it. In the past, spending was essential, which led to some activities being overlooked or things you wanted to do being neglected. Consequently, you find yourself hurrying through these tasks instead of approaching them as you normally would*. …." (KII, Western Zone, Field Interview).

Some healthcare facilities reported that staff receiving allowances from HBF become demotivated when there are delays in fund disbursement.

…. One significant issue is that employees whose salaries are funded through HBF lack motivation; they do not work with enthusiasm…. Furthermore, within the administration, if funds are allocated for paying electricity bills, fuel, or incentives and uniforms, delays can occur, affecting both incentives and administrative operations. …." (KII, Coastal Zone Field Interview).

…. *The most significant impact, as we mentioned, is that certain activities must be forgone due to decreased funding. However, as a region, we often find ourselves needing to address these challenges. For example, we may need to involve a pharmacist who collaborates with the RDO to assess the situation at the centre. The pharmacist has an approved activity that requires my attention, so I rely on the RDO to help me understand how things are progressing. As a result, we are compelled to pursue integration; ideally,*

there shouldn't be too large a gap, but the quality of the activities still falls short of our expectations…." (FGD, Southern Zone Field Interview).

Effect on targeted indicators

Majority of the participants reported that the delays affect the achievement of targets based on indicators linked to HBF resources. For example, delays affect the availability of healthcare commodities because funds are inadequate. Still, with limited funds coming in, the medicine runs out before additional money arrives, resulting in fewer activities being carried out or some being completely neglected.

> "… *The impact on indicators should not be targeted for achievement by that time. For example, in maternal and child care, all mothers should receive testing for folic acid and blood-thinning medications. However, these indicators are sometimes not met because we, as the CHMT, have not conducted field supervision to identify the challenges*. …." (KII, Southern Highlands Zone, Field Interview).

> *"…. One effect is the inability to achieve your planned goals. When the next financial year arrives, you may fall short of the performance indicators, resulting in reduced funding. This failure to implement on time affects not only monetary support but also other activities that require funding. For example, training necessitates bringing in participants, providing food, and accommodating them, all of which require cash or funds in an account. Additionally, supervision work requires fuel; while we can borrow fuel for this purpose, external factors like epidemics can impact our resources. If funding for health commodities decreases, we must redirect money to address outbreaks and manage the situation. …."* (FGD, Lake Zone, Field Interview).

> "…. *I have seen and heard, especially during these times of medicine shortages, that many patients we serve rely on exemptions, and our centre's income is inadequate to purchase the necessary medications. There are instances when we request medicines from the pharmacy, only to be informed that we lack sufficient funds. We believe that if our funding had arrived, we would have been able to buy the needed medications*. …." (FGD, Lake Zone, Field Interview).

In some interviews conducted at the facility level, it was noted that the delays impact the provision of outreach services. Delays in providing outreach services, whether due to logistical challenges, resource constraints, or other factors, can hinder effective service delivery and negatively affect the individuals and communities that depend on these services.

> "… *One effect is the effectiveness of health activities. For example, when conducting outreach for vaccinations, it can be challenging to motivate an employee if they haven't been paid for the previous quarter. Expecting them to participate in outreach without compensation diminishes their motivation. Additionally, the same funds may be required for transportation to the outreach site, necessitating alternative solutions to ensure attendance.* …." (KII, Southern Highlands Zone, Field Interview).

3.4.4 Variability across Councils and Funding Sources

Disbursement timelines vary by source. For example:

- DPs adhering to results-based disbursement release funds after the IAG report, often in Q2 or Q3.
- DPs with more flexible arrangements (e.g. UNICEF) occasionally front-load a portion of their annual commitment to cushion delays.

Moreover, some councils experience smoother fund flows due to better coordination with MoF or proactive local planning. However, this variability undermines system equity and predictability.

> "*Why should some councils receive early funds and others not? The rules should be the same for all*." (KII, DP representative Field Interview).

3.4.5 Proposals Discussed to Improve Timeliness

During the MTR, key stakeholders proposed several adjustments to improve the timeliness of HBF disbursements. These suggestions reflected both policy-level insights and operational experiences from facility and council levels:

- **Delinking Side Agreements from the IAG Report:** For DPs not using performance-based disbursement modalities, it was recommended that fund releases be based on the approved annual plan and budget, rather than being delayed until the IAG report is finalized.
- **Staggered or Phased Disbursements:** Stakeholders advocated for partial releases - particularly for the first quarter - based on provisional approval, with remaining tranches disbursed upon receipt of the IAG report or performance verification. This approach could also be adapted by DPs applying results-based funding (e.g., the World Bank), enabling early liquidity while maintaining accountability.
- **Advance Planning of IAG Terms of Reference:** Finalizing and sharing the IAG's Terms of Reference earlier in the fiscal cycle could accelerate the audit process and minimize bottlenecks at the start of the financial year.
- **Digital Monitoring of Fund Flows:** National-level respondents proposed establishing a digital tool to track disbursements along the entire fund flow chain - from budget allocation by MoF, to notifications and requests by MoH and PO-RALG, to final receipt by LGAs and facilities. This system would replace the current manual "fund floor" tracking approach and improve real-time transparency.

  "Currently, we employ a manual follow-up process. I advocate for implementing a systematic approach to track each step. It would enhance transparency about where delays occur and allow more effective follow-up." (KII, GoT official, Field Interview*).*

  "The establishment of such a system would not only promote accountability but also enhance the timely tracking of disbursements. By monitoring delays on an annual basis, we can significantly expedite the process." (KII, GoT official, Field Interview*).*

  Stakeholders recommended that the tool operate as a dashboard, with clear milestones and time benchmarks for each stage. It should generate alerts when delays arise, support joint follow-up across institutions, and feed regular reporting into quarterly and annual HBF reviews. Integration with existing platforms such as PlanRep and FFARS was suggested to avoid duplication - though this will require technical feasibility assessment.
- **Forecasting and Contingency Mechanisms:** Some DPs proposed enhancing disbursement predictability through quarterly cash forecasts, transparent disbursement calendars, and a pooled liquidity buffer to manage short-term delays.
- **Automation of Triggers:** A forward-looking proposal involved linking disbursement triggers to verifiable inputs from systems such as DHIS2 and PlanRep, reducing bureaucratic bottlenecks and enhancing responsiveness.

  "Let's treat HBF like a modern fund—with rules, reserves, and real-time triggers." (KII, DP representative, Field Interview).

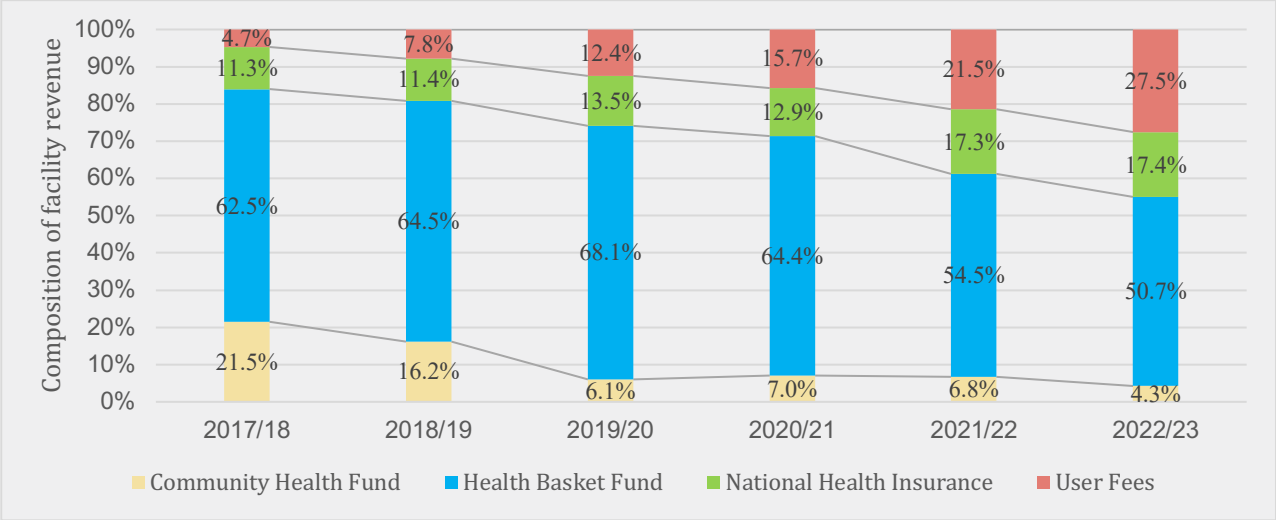
These proposals collectively underscore the recognition that operational delays compromise planning and service delivery. By enhancing transparency, predictability, and automation, HBF could evolve into a more real-time, responsive funding mechanism without undermining accountability.

3.5 Expenditure Patterns and Utilization

3.5.1 HBF contribution to the overall primary healthcare financing

According to Binyaruka *et al*. (2024), the study on provider autonomy in the context of primary care facilities reveals that HBF constitutes the largest proportion of health facilities' revenue in the Singida region, accounting for approximately 61% of total revenue. The share of HBF increased from 62.5% in 2017/18 to 68.1% in 2019/20, followed by a decline to 50.7% in 2022/23. This trend is consistent with the national pattern observed in total donor financing to the health sector, where the share of donor financing in CHE decreased from 34% in 2017/18 to 23% in 2021/22. As the proportion of HBF revenue declines, health facilities are increasingly reliant on direct out-of-pocket payments as a source of revenue. Out-of-pocket (OOP) payments or user fees now account for approximately a quarter of the current health expenditures for health services in Tanzania. At the regional level, for example, Singida Region experienced a marked increase in revenue from user fees, rising from 4.7% in 2017/18 to 27.6% in 2022/23 At the national level, OOP payments remained relatively stable, ranging between 22% and 27% from 2015/16 to 2021/22 (Figure 6). Despite the initially lower level of user fee revenue in Singida Region in 2017/18, both regional and national data clearly demonstrate that user fees now represent a substantial share of health facility financing.

Figure 6: Composition of facility revenue in Singida region, FYs 2017/18-2022/23.



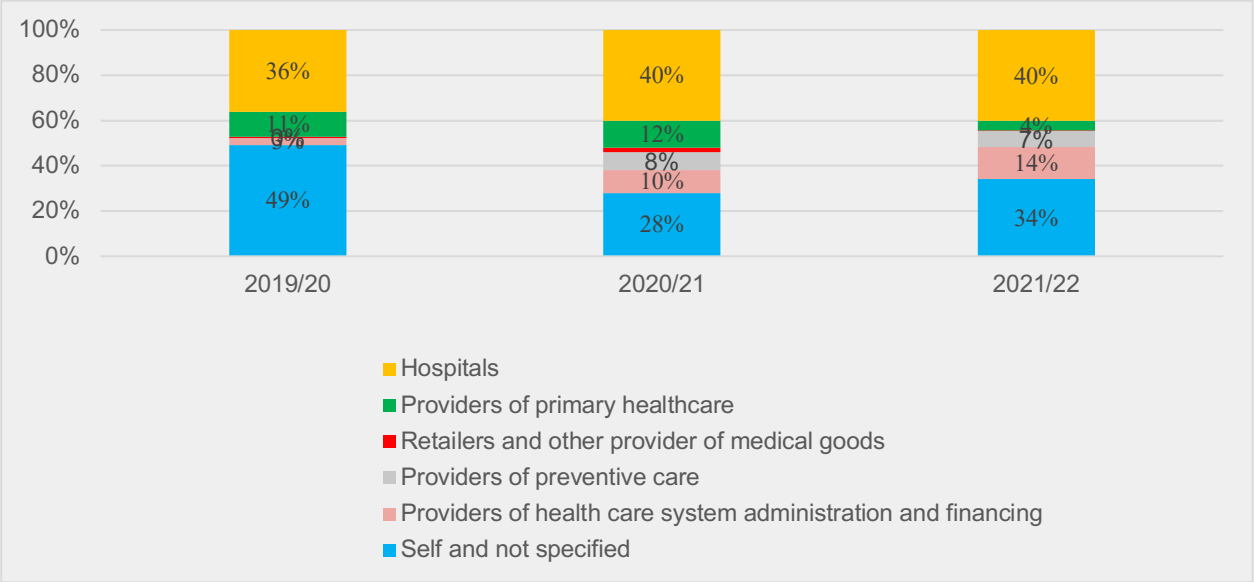
Source: Adapted from Binyaruka *et al*., (2024).

3.5.2 Expenditures by health care providers

Despite the reported increase in health expenditure by the MoH, primary healthcare receives a relatively small share of the total health budget. According to the MoH Annual Health Sector Performance Profile 2023 (MoH, 2024), Total Health Expenditure (THE) reached 6.83 TZS trillion (approximately USD 2.9 billion) in 2022, marking a 26 percent increase from 5.35 TZS trillion (approximately USD 2.3 billion) in 2020. The report further indicates that in 2022, THE accounted for 5 percent of GDP, an increase from the 4 percent recorded in 2020.

Government expenditure on health, as a percentage of total government expenditure, rose from 6 percent in 2020 to 8 percent in 2022. Per capita health spending reached 114,752 TZS (USD 50) in 2022, up from 95,292 TZS (USD 40.9) in 2020. Expenditure at referral hospitals, which includes district hospitals and national facilities, increased to 40 percent in 2022, up from 36 percent in 2020.

Figure 7: Share of Health Expenditure by Providers



Source: Annual Health Sector Performance Profile 2023

3.5.3 Overview of Expenditure Categories

HBF resources at council and facility levels are allocated across several key spending categories, guided by national planning instruments such as the Comprehensive Council Health Plans (CCHPs) and budget ceilings communicated via PlanRep. The standard expenditure categories include:

- Medicines and Medical Supplies
- Health Facility Maintenance and Infrastructure
- Outreach Services
- Training and Capacity Building
- Supervision and Monitoring
- Administrative Costs

Each of these categories is guided by planning instructions and indicative thresholds. For instance, facilities are required to allocate a minimum of 35% of their HBF resources to medicines and medical supplies. Compliance with these spending thresholds is monitored through FFARS.

> "*The budget categories are rigid. Sometimes you have money for outreach but no funds left for essential repairs or staff incentives.*" (Health Centre In-charge, Western Zone, Field Interview).

Although facilities rely on multiple sources of funds, including user fees and insurance reimbursements, similar constraints apply to NHIF and CHF funds. Delays in reimbursement from

CHF and NHIF schemes were frequently cited in the field. Facilities struggle to track submitted claims, leading to uncertainty in procurement and implementation.

> *"You spend first, then wait months for CHF. Sometimes we're not sure if it will even come."* (Health Centre In-Charge, Coastal Zone, Field Interview),

3.5.4 Adherence to Expenditure Guidelines

Analysis of FFARS data from FY 2020/21 to 2023/24 shows general compliance with prescribed ceilings, particularly the 35% earmarking rule for medicines and medical equipment. However, facilities frequently report misalignment between these standard rules and their actual needs.

This has led to underutilization or inefficient use of funds in several councils. Interviews and expenditure records confirm:

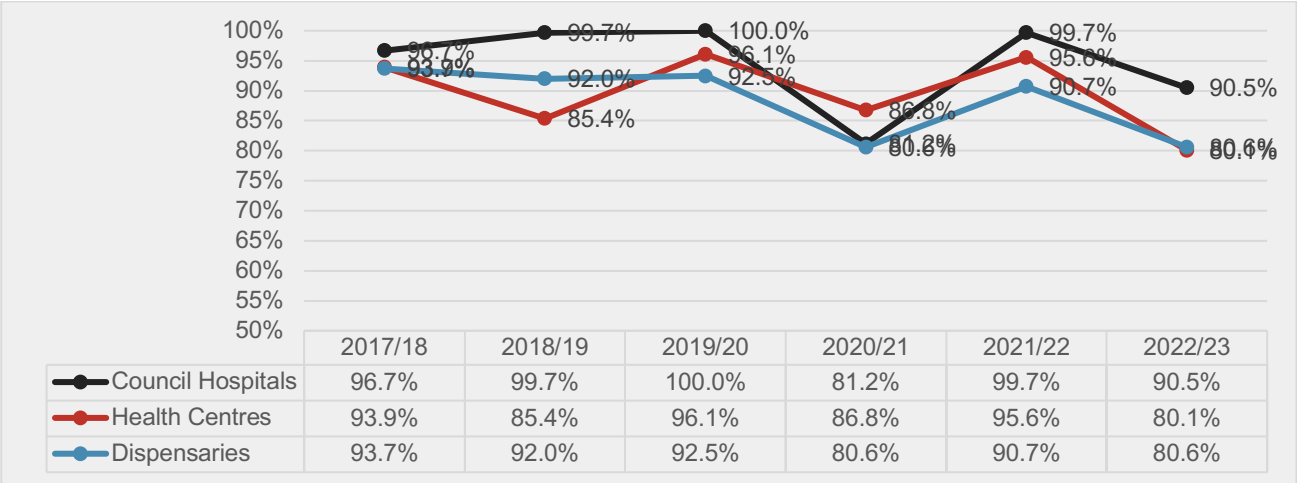
- Overspending on medicines in some cases due to low stock from MSD or delays in deliveries.
- Underspending in categories such as infrastructure, where procurement is more complex or constrained by technical capacity.
- Reallocation delays or denials when facilities request to shift funds across categories.

"*Medicines are out of stock, but we still must follow the 35%. We cannot use the funds to fix the water system or repair a delivery bed*." (CHMT Accountant, Central Zone, Field Interview)

3.5.5 Utilization of the funds and execution of the budget

In addition to the findings from secondary analysis from FFARs, published literature (Binyaruka *et al*. 2024) shows that budget execution varied across facilities and over time. In FY 2022/23, for instance, execution rates ranged from 80% to 90%. The average execution rate of DFF-HBF funds by council hospitals was 95% (with a range of 81–100%) during the analysed period, which was higher than that of health centres, which averaged 90% (with a range of 80–96%), and dispensaries, which averaged 88% (with a range of 80–93%) (Figure 8).

Figure 8: HBF execution rates by type of facility, FYs 2017/18-2022/23.



Source: Adapted from Binyaruka *et al*., (2024).

While overall fund utilization rates appear high on paper (averaging 85–95% across councils), this metric can be misleading. Several underlying issues affect the efficiency and timeliness of actual spending:

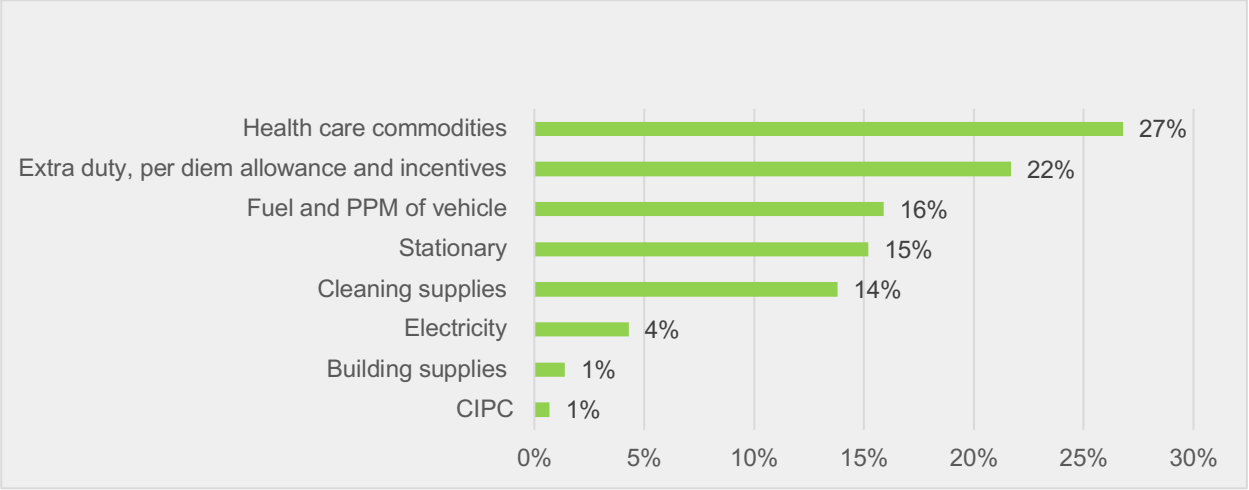
- **Late Disbursements** (as discussed in Section 3.4) compress implementation timelines and create a rush to spend in Q3 and Q4.
- **Procurement Bottlenecks**, particularly for non-medical supplies and infrastructure maintenance, often delay spending.
- **Limited Local Capacity** to manage procurement processes at the facility level results in carryovers or sub-optimal use of funds.

"*We spend quickly at the end of the year to show 100% absorption, but that doesn't always mean the services improved*." (CHMT member, Lake Zone, Field Interview).

In 2023, PO-RALG, in collaboration with the MoH, conducted a financial monitoring visit focused on the HBF to assess challenges in fund utilisation at healthcare facilities in Shinyanga District Council (DC), Ushetu DC, and Msalala DC (MoH & PO-RALG, 2023). The primary objective was to evaluate the financial performance and implementation of health projects at selected primary healthcare facilities. The review confirmed that all facilities had received HBF funding in each of the four quarters of the 2021/2022 fiscal year. However, MoH and PO-RALG staff observed that, in several cases, the funds were used in ways that contravened established HBF guidelines (MoH & PO-RALG, 2023). The monitoring report noted that some facilities had spent funds on items such as payments for labourers, security services, electricity, and water - expenditures not aligned with the intended use of the fund. According to HBF guidelines, each facility is required to allocate one-third of HBF resources to healthcare commodities (Maiba *et al.*, 2023).

Figure **9** illustrates the main expenditure categories for HBF resources based on an assessment of DHFF implementation in health facilities within LGAs, conducted by the MoH and PO-RALG. The largest share of HBF funds (27%) was allocated to the procurement of healthcare commodities. This was followed by 22% for additional duties, per diem allowances, and incentives. Fuel and patient care management accounted for 16% of expenditures, while 15% was spent on stationery and 14% on cleaning supplies.

Figure 9: Utilization of HBF funds at health facility level in 2022/23



Source: URT, (2023e). Report on Monitoring the Use of Health Basket Fund Funds in Local Government Authorities. Dodoma, Tanzania.

Additionally, health facility respondents widely reported that inflation and rising operational costs are undermining the real value of allocated budgets. Despite high nominal execution rates, many facilities find that funds now cover fewer services or inputs compared to previous years. Budget

ceilings - particularly those set in fixed amounts or percentages - have not been adjusted to reflect this cost escalation, placing further pressure on procurement and outreach activities.

> *"This year, the same outreach now costs 30% more. But our budget is the same." (*Facility Accountant, Health Centre, Central Zone, Field Interview).

3.5.6 Trends by Facility Level and Expenditure Type

Analysis of spending patterns shows distinct differences between facility types:

- **Dispensaries** tend to spend a larger proportion on medicines and supervision due to their basic service mandate and lack of infrastructure budgets.
- **Health Centres** have more diversified expenditures, including minor infrastructure works, training, and maternal health outreach.
- **District Hospitals** have more flexibility and better administrative support, enabling them to absorb and utilize funds more efficiently.

Health centres serve a larger population and broader service range, yet staff at both urban and rural facilities noted that resource allocations often fail to reflect their actual burden. Urban health centres faced high patient loads and pressure to deliver comprehensive services, often without proportional increases in budgets.

> *"We run as a mini-hospital, but are funded like a dispensary."* (HFGC Chairperson, urban health centre, Lake Zone, Field Interview).

Data suggest that facilities with higher administrative staffing (e.g. health centres) perform better in terms of utilization rates and quality of planning.

> "*We support our assigned dispensaries with accounting and planning. They don't have the staff to handle the paperwork alone*." (Health Centre Administrator, Northern Zone, Field Interview).

Hospitals frequently emphasized a mismatch between their responsibilities—especially as referral points—and the limitations of HBF budget ceilings. While some funds are earmarked for medicines and minor renovations, there is limited flexibility for high-priority needs such as blood transfusion supplies, oxygen systems, and specialist referrals.

> *"Patients are referred here without transport or drugs, but we get no extra for it."* (Medical Officer in-charge, district hospital, Lake Zone, Field Interview).

> *"Our lab refrigerator broke, but there's no line in the budget to fix it."* (Facility In-charge, rural hospital, Southern Zone, Field Interview).

3.5.7 Procurement Practices and Facility-Level Flexibility

Across all levels of the health system, persistent stock-outs of medicines and medical supplies were among the most frequently cited operational challenges. Facility in-charges and HFGC members alike attributed the problem primarily to delays or under-delivery from the MSD. While the implementation of DHFF has enhanced funding availability at the facility level, ensuring timely and sufficient procurement of essential items remains a bottleneck.

To compensate for supply gaps, health facilities rely on a mix of procurement approaches:

- **Jazia PVS**: Introduced as a supplementary procurement mechanism, Jazia PVS was generally perceived as a valuable alternative when MSD fails to deliver. Facilities reported that Jazia PVS often provides faster turnaround and can respond to urgent supply needs. However, the system is not without its limitations. Some respondents noted that not all items are covered under Jazia contracts, while others reported that vendors lacked the capacity to deliver complete orders. Delivery logistics, especially to remote rural areas, further complicated the system's reliability. One urban facility in-charge described Jazia as "only half-functional," whereas a rural health centre HFGC member referred to it as a "lifesaver" during critical shortages.
- **Direct local procurement**: Particularly in emergencies, dispensaries and health centres reported buying medicines and supplies from local pharmacies. This practice was more common in urban areas with accessible markets but is constrained by procurement ceilings and fear of audit repercussions. As one health centre in-charge explained: *"We sometimes buy gloves or paracetamol locally, but this is not formally approved and must be justified carefully."*
- **Constraints from expenditure ceilings and fund segmentation**: Several respondents criticized the inflexibility of funding guidelines. For instance, HBF mandates that **at least 35% of facility funds be used for medicines and medical supplies**, a policy considered too rigid in situations where needs shift dynamically. Similar constraints apply to NHIF and iCHF reimbursements. Facility managers indicated that although funds may technically be available, fixed ceilings and budget codes often restrict their reallocation.

  "Even if a child dies of malaria, I cannot buy the rapid test if it's not in the approved plan." (Facility In-Charge, Urban Dispensary, Coastal Zone, Field Interview).
- **Facility-level innovations and coping mechanisms**: Despite these constraints, health facilities have adopted creative workarounds. Some pre-order common items in bulk at the start of the quarter. Others pool resources across multiple funding streams - including HBF, user fees, and iCHF - within what is allowed. In a few districts, CHMTs supported facilities with provisional approval for urgent procurements followed by post-facto justification.
- **Differences by facility type and location**: Urban facilities benefit from better access to commercial suppliers and more robust planning capacity, allowing more flexibility in coping with shortages. Rural facilities, on the other hand, remain highly dependent on MSD and Jazia PVS, facing longer replenishment cycles and greater challenges navigating digital systems like PlanRep. These disparities underscore the need for tailored approaches to planning and budget flexibility.

CHMT and RHMT perspectives revealed mixed experiences with the facility prioritization process. While CHMTs acknowledged the empowerment of HFGCs in budgeting, many observed limited strategic thinking, especially in low-capacity rural councils. There were calls for minimum ceilings for essential maintenance or non-clinical expenditures.

"Dispensaries may prioritize painting over fixing leaking roofs." (CHMT member, Central Zone, Field Interview).

*"Without ceilings for critical categories, some councils run essential services on zero budget." (*RHMT member, Coastal Zone, Field Interview).

While field suggestions included introducing a share of discretionary funds or allowing in-year budget revisions based on performance and emerging needs, stakeholders also recognized that unregulated local procurement carries risks. The Jazia PVS was deliberately designed at the regional level to ensure economies of scale, control fraud, and maintain quality assurance through a government-supervised contracting process.

In conclusion, enhancing facility-level flexibility is essential for responsive service delivery but must be balanced with adequate oversight. Reforms should aim to streamline procurement pathways, revise ceilings where appropriate, and empower local actors to act swiftly, while preserving accountability through structured, well-regulated systems.

3.5.8 Global (SDGs), country (policy) and partner/institution priorities

All the HBF Development Partners and government representatives from the MoH and PO-RALG agreed that the HBF intervention objectives and design respond global (SDGs), country (national health policy, URT 2017a) and partner/institution needs policies and priorities. Arguments were also based on the assertion that the basket is integrated into a sector-wide approach, thereby establishing a significant link to global developments. MoH and PO-RALG representatives argued that the formulation of the health sector guidelines and strategic documents is informed by the international evidence including WHO formal documents. Health sector priorities are established in line with the existing international guidelines. Half of the health financing experts (2/4) noted that the HBF aligns with global priorities, donor partners, and country policies. At the sub-national, in all the focus group discussions at the regional (7) and council level (17) they reported that the guidelines for the HBF aligns with country policy and national priorities including the ruling party manifesto. The current party manifesto emphasizes maternal health, medicine availability, and control of communicable diseases, which align with the Basket Fund's focus. Additionally, the Sustainable Development Goals aim to reduce maternal mortality by fifty percent by 2030, and the Basket Fund allocates a significant portion of its budget to reproductive and maternal health services. Overall, Tanzania has made progress towards achieving RMNCAH+N impact indicators during its first implementation of the HSSP V and One Plan III (URT, 2021b; URT, 2022c). Institutional Maternal mortality that occurs in health facilities declined from 94 in 2018 to 65 per 100,000 live births in 2023, averaging 78 over six years, from MPDSR data. Regional referral hospitals accounted for one-third of deaths, followed by district hospitals (29%) and health centres (20%) (MoHCDGEC 2021; Mtenga et al., 2025).

" .. *It is through the government system that we align closely with the strategic plan. This strategic plan is in line with the government's national vision plan, which in turn aligns with the SDGs. It's a cascading approach; we begin at the global level and then move to the national. However, I believe the national framework is more important initially because if we are not well organized at the national level, even the global policies and goals will be unattainable*." (KII, DP, representative, Field Interview).

"…*The target is established based on the health sector's strategic plan. We are currently implementing Health Strategic Plan Five, in which stakeholders, including the government and our partners, collaborate to review international guidelines such as the SDGs and WHO recommendations. From this analysis, we set our targets*." (MoH, Field Interview)

"…*As long as it is integrated within the central framework, it aligns with the country's various national priorities. These priorities are cascading down to the councils, which are developing their*

plans based on strategic objectives. The councils' strategic plans identify key priorities for resource allocation. Additionally, these priorities are being integrated into the planning and budgeting processes." (Health Financing Expert, Field Interview)

"…*The advantage of the planning system is that all interventions must be connected to national priorities, global development goals, Vision 2025, and the ruling party's manifesto. No plan is approved unless it relates to the established national or global priorities. As the Regional Health Management Team, we are responsible for ensuring that all plans align with national, political, and global priorities. We cannot exceed those boundaries. In that sense, everything is aligned*." (Focus group discussion, RHMT, Field Interview).

3.5.9 Facility-Level Prioritization – gender- responsiveness

The funds are utilized according to a plan that includes designated priorities, notably the health needs of women and girls. More than half of the respondents from dispensaries (21/33) and health centres (19/34) reported that they incorporate adolescent-friendly service considerations when formulating plans and budgets. Resources are commonly allocated for education on HIV prevention, testing, the risks of early sexual activity, and gender-based violence (GBV). Adolescents are also encouraged to report incidents of abuse and are linked to social welfare officers for follow-up support.

The HBF additionally supports family planning services targeting women of reproductive age and funds staff allowances for those conducting outreach to youth and adolescents. Educational programs addressing teenage pregnancy are widespread, reflecting the observed prevalence among individuals under the age of twenty.

These activities were echoed in several interviews, where staff emphasized the importance of outreach, school-based seminars, and free reproductive services as routine components of HBF-supported interventions.

Across all regional (7) and council-level (17) focus group discussions, participants confirmed that the HBF's objectives and structure align closely with the specific needs of women and girls. It was broadly acknowledged that the Fund has significantly advanced adolescent health through its support for maternal and child health services. This includes comprehensive reproductive health education, teenage pregnancy prevention, and reductions in maternal mortality. The HBF has also supported STI education, while maternal and child health clinics have been designed to include adolescent-friendly spaces and services.

Reproductive and child health is consistently ranked as a top priority (second only to essential medicines) within HBF-supported planning. As such, funds are purposefully directed toward interventions for women and adolescent girls.

CHMT and RHMT respondents confirmed this prioritization:

> *"…. The Basket Fund emphasizes several priorities for women and girls when allocating funds in our city, with a particular focus on pregnant women. By addressing the needs of pregnant women, we effectively address the needs of all women. For girls, we prioritize their specific service requirements, recognizing that they require different support compared to boys."* (CHMT member, Northern Zone, Field Interview).

> *"… Women and girls are prioritized in reproductive and child health and maternal care, which are key focus areas. Gender and youth are also considered within these categories. Additionally, social welfare, which is part of the health sector, integrates these priorities*

into our activities, ensuring that the guidelines address all target groups." (RHMT member, Northern Zone, Field Interview).

While CHMT respondents broadly affirmed alignment of facility plans with gender priorities, some highlighted the lack of structured tools or budget-tagging mechanisms at council level. This limits their ability to systematically prioritize gender-specific needs when consolidating plans in PlanRep: *"We try to address women's health, but there's no checklist or gender budget guideline at council level."* (CHMT Member, Lake Zone).

"…They align well. Among the health priority areas, maternal, reproductive, and child health is ranked second, following essential medicines. Additionally, there are

interventions specifically targeting adolescent reproductive health." (CHMT member, Eastern Zone, Field Interview).

" … For pregnant women receiving maternal care, I believe the alignment is perfect. The fund usage guidelines and their percentages clearly support services for women and adolescent girls, who also benefit from health services at our facilities." (CHMT member, Western Zone, Field Interview).

Despite the strong operational alignment at facility level, national experts pointed to a **strategic planning gap** in formal gender-responsive budgeting. They noted the absence of clear tools within FFARS and PlanRep to tag or prioritize expenditures related to GBV, adolescent health, or broader reproductive justice.

*"Right now, gender-responsiveness is aspirational, not operation*al." (KII, Senior Health Specialist, Field Interview).

This highlights the need for **upstream reforms**, including strengthened planning guidance and the introduction of mandatory tracking indicators, to ensure consistent and system-wide prioritization of gender-focused spending.

3.6 HBF Implementation Success:

The effectiveness of HBF implementation is measured through a set of performance indicators tracked at facility and council levels. These include service delivery outputs (e.g., facility deliveries, OPD visits), structural indicators (e.g., staff availability, equipment functionality), and financial performance (e.g., budget execution rates). This section reviews key implementation successes that have enabled these outcomes.

3.6.1 Availability of Tracer Medicine

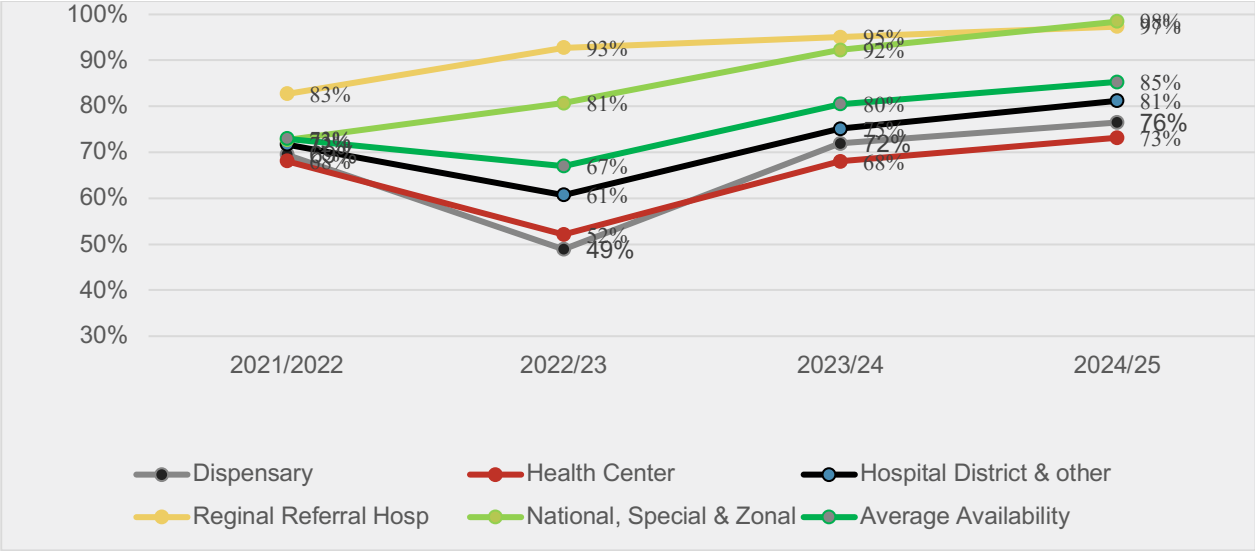
The Health Sector Strategic Plan for July 2021 to June 2026 stipulates that the government will improve the availability of medicines, health commodities, medical devices, and supplies to meet the population's needs. In addition, the Medical Stores Department Medium Term Strategic Plan (MTSP III) (2021-2026) indicates that as of 2020/21 stock availability averaged 66% against the target of 90%, while inventory accuracy averaged 98% against the target of 100%. The order fill rate from MSD to facilities averaged 68% compared to the annual target of 90% as of 2020/21 fiscal year, using the current tracer list of 261 items (URT, 2021a). Report of the 23rd Joint Annual Health Sector Technical Review Meeting indicates that the availability of 30 essential medicines have increased from 41% in 2007 to around 90% in 2021 (URT, 2023c). Whereas the annual health sector performance profile of 2023 showed that the average availability of 30 tracer medicines was 92.7% in 2023, this is slightly lower than the 94.48% of 2022 (MoH, 2024). The

implementation of public-private partnerships (PPPs), such as the Jazia Prime Vendor System (Wiedenmayer et al., 2019), as outlined in Health Sector Strategic Plans IV and V, has been recognized as a key factor in improving the availability of healthcare commodities nationwide since its rollout in 2018 (Elias & Mushi, 2024; Pyuza et al., 2023).

Facilities do not possess the flexibility to independently reallocate funds beyond predefined ceilings. The HBF covers cost associated with the procurement of medicines, medical equipment, and supplies, as well as improvements to the delivery of quality healthcare to the Tanzanian population. A study conducted in Tanzania disaggregating health commodity funds by their sources revealed that the HBF was the largest contributor, accounting for approximately 63.0% of total expenditures in 2017/18 (Ruhago *et al*., 2023). However, this contribution declined to 45.7% in 2020/21. In contrast, user fees have increasingly become a significant source of funding, rising to approximately 31.7% in 2020/21, up from 10.5% in 2017/18.

Figure 10 below shows the improvement in the availability of the MoH tracer basket of 290 essential health commodities from 2021 to 2024. These resources, however, still fall short of meeting healthcare requirements across hospitals of all levels and specialties. Although there have been improvements in the efficiency of medicine supply, further measures are needed to enhance the supply chain, particularly in logistics and storage. There is a pressing need for alignment among various funding channels, including the DHFF and other programmes, in procuring healthcare commodities.

Figure 10 Availability of Priority Essential Health Commodities 2021-2024



Source: MoH 2024, Availability of 290 Priority Health Commodities for Primary Health Facilities - Dispensaries, Health Centres and District Hospitals

The Tanzania Service Availability and Readiness Assessment (SARA) which assessed only 15 tracer basket medicines showed on average, facilities had 9 out of 15 basic essential medicines, resulting in an average medicine readiness score of 55 out of 100. The mean availability of essential medicines at the time of healthcare facility visit was 60% for dispensaries, 83% for health centres, 89% for council hospitals, and 89% for referral hospitals. In terms of managing authorities, the readiness rates are as follows: government/public (67%), NGO/not-for-profit (69%), private-for-profit (51%), and mission/faith-based (67%) (MoH, 2024). The Annual Health Sector Performance Profile 2023 showed that the availability of 290 priority health commodities has increased from 63% in 2022 to 76% in 2023 (MoH, 2024). In 2023, the availability varies by regions, ranging from 55% in Songwe region to 89% in Singida region (MoH, 2024).

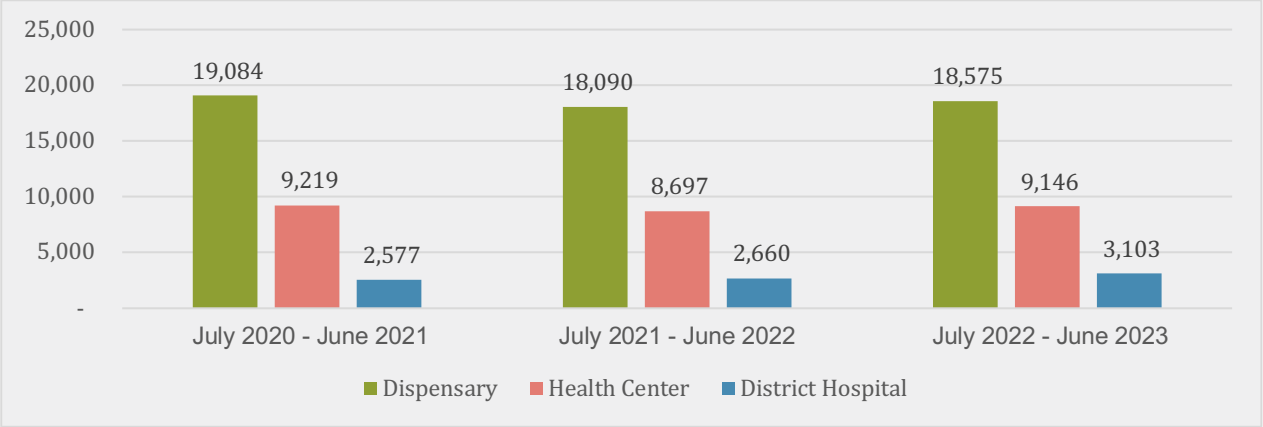
3.6.2 Number of Outpatient Department – OPD visits

The SARA showed that general service readiness indicates that healthcare facilities are 71% ready to provide basic services (MoH, 2024). This is 2% higher compared to the general service readiness in SARA 2020 (69%). Over the past 11 years, since 2012, there has been an improvement of over 30% in the readiness of facilities to provide basic services (MoH, 2024).

The HBF has been supporting health service delivery towards UHC. HBF monitoring uses several indicators, including six quantity indicators of service utilisation: Outpatient visits, antenatal attendance, institutional deliveries, postnatal attendances, admissions, and C-sections. Other indicators relate to performance and quality, such as the availability of 30 tracer medicines and family planning use (see Annex 2: DHIS2 - HBF Indicators).

Outpatient indicators in Tanzania are designed to monitor and improve the quality and efficiency of healthcare services delivered in outpatient settings. This encompasses primary healthcare facilities, including health posts, health centres, and district hospitals. High OPD visits are observed within the dispensaries for all the three years. OPD attendance at district hospitals increased from 2,577 to 3,103 for the FY 2020/21 to FY 2022/23 (Figure 11).

Figure 11: OPD total attendance 2020/21 - 2022/23, '000

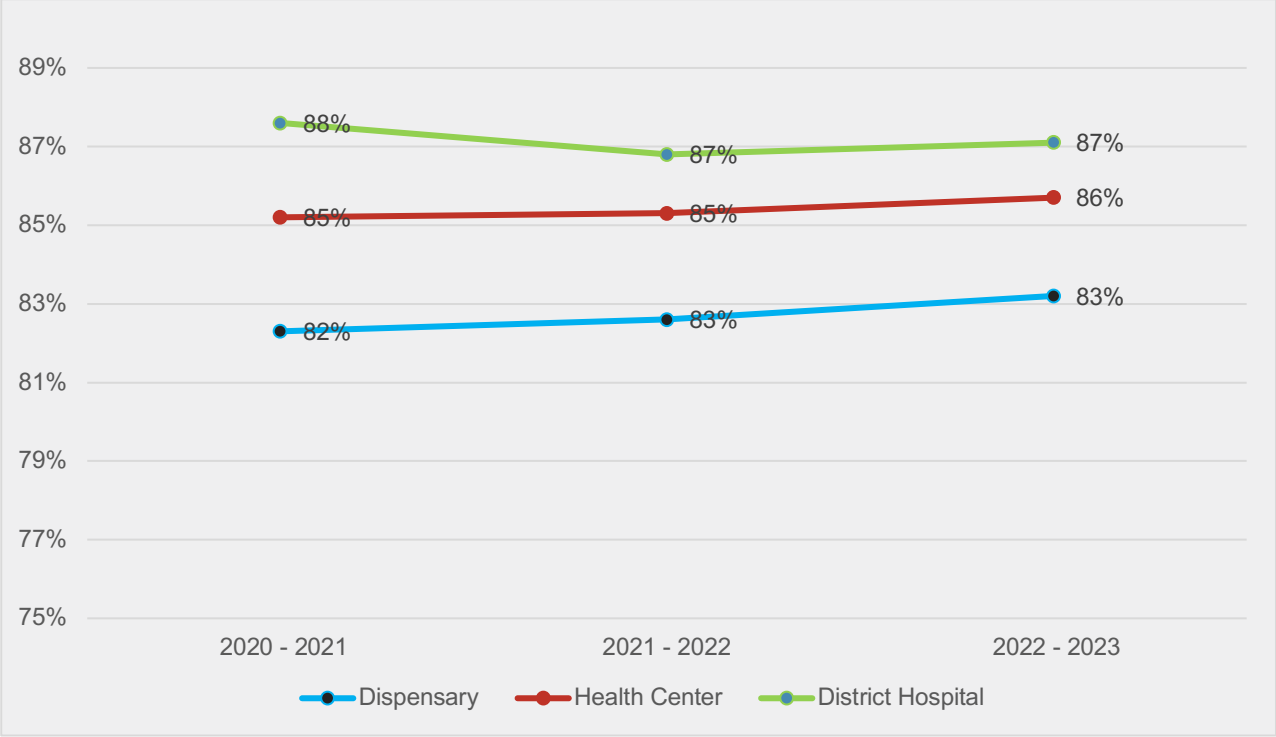


Source: MoH – DHIS2; figures are in '000.

3.6.3 Percentage of pregnant women aged 20 years and above attending first ANC visit

Ante-natal Clinic provides an important opportunity for pregnant women through a wide range of interventions and is considered a fundamental component of reproductive care. To ensure the full range of life-saving interventions, ANC requires pregnant women to attend at least four visits before delivery. The DHIS2 report for 2020/21 indicates that the percentage of women attending four or more ANC visits was 82% at dispensaries, slightly rising to 83% in 2022/23 (Figure 12). This is slightly lower than the 90.2% reported in 2020 from the Independent Verification of Health Service Results supported by the Health Basket Fund and the Strengthening of Primary Health Care for Results (URT, 2020a; URT, 2021d).

Figure 12: Percentage of pregnant women 20 years and above attending first ANC visit

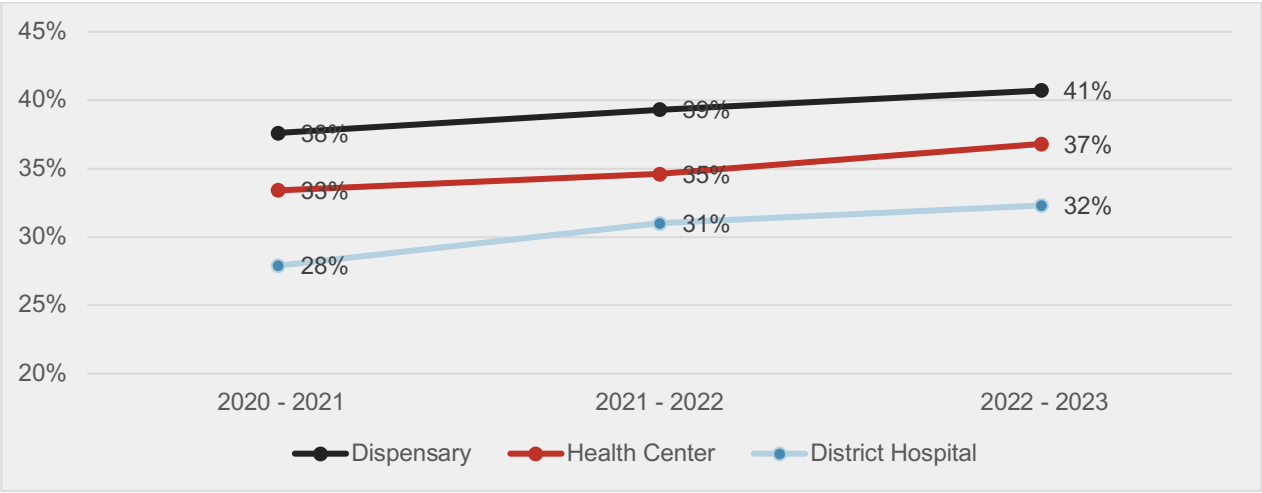


Source: MoH – DHIS2

3.6.4 Percentage of pregnant women who attended ANC before 12 weeks gestation

Figure 13 shows the proportion of pregnant women who attended ANC at different healthcare facility levels before 12 weeks' gestation. During the financial year 2021/22, 38% of pregnant women attended ANC at dispensaries, while 33% and 28% attended at health centres and hospitals, respectively. There was a slight increase in attendance percentages across all facility levels, with attendance at dispensaries rising by 3 percentage points for the financial year 2022/23, and attendance at health centres and hospitals increasing by 4 percentage points in the same financial year.

Figure 13: Percentage of pregnant women who attended ANC before 12 weeks gestation

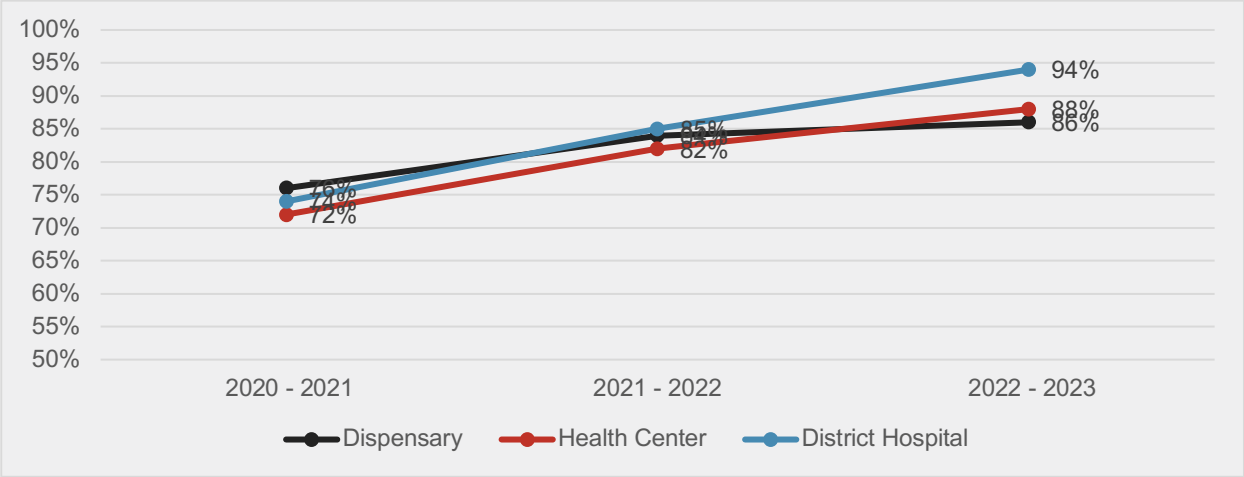


Source: MoH – DHIS2

3.6.5 Percentage of pregnant women provided with IPTp2 during ANC visits

The DHIS2 report indicates that during the FY 2020/21 the percentage of mothers who received two doses of “intermittent preventive treatment during pregnancy” (IPTp2) for malaria was 76% for dispensaries, 74% for health centres, and 72% for hospitals (Figure 14). The percentage of pregnant women receiving IPTp2 during ANC visits increased across all facility levels, with dispensaries rising by 10 percentage points in the financial year 2022/23. In the same financial year, health centres and hospitals increased by 16 and 20 percentage points, respectively.

Figure 14: Percentage of pregnant women provided with IPTp2 during ANC visits

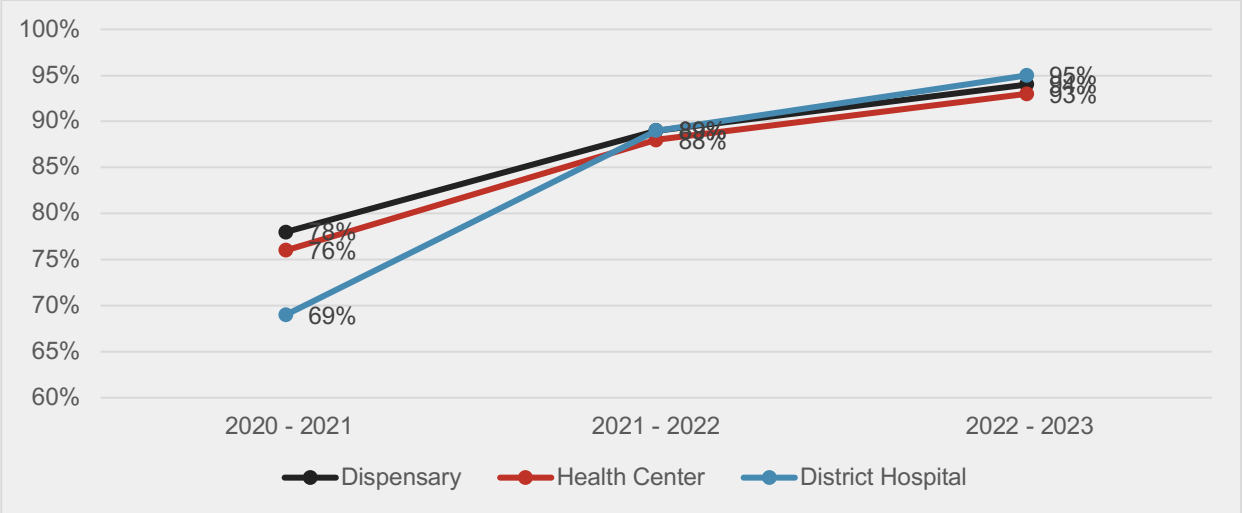


Source: MoH – DHIS2

3.6.6 Percentage of pregnant women received FEFOL (Iron Folic) supplementation

The DHIS2 report indicates that, during the financial year 2020/21, the percentage of pregnant women receiving FEFOL (Iron Folic) supplementation was 78% in dispensaries, 76% in health centres, and 69% in hospitals. The percentage increased substantially across all facility levels, with dispensaries reaching 94% in the financial year 2022/23. In the same financial year, health centres and hospitals achieved 93% and 95%, respectively (Figure 15).

Figure 15: Percentage of pregnant women received FEFOL (Iron Folic) supplementation

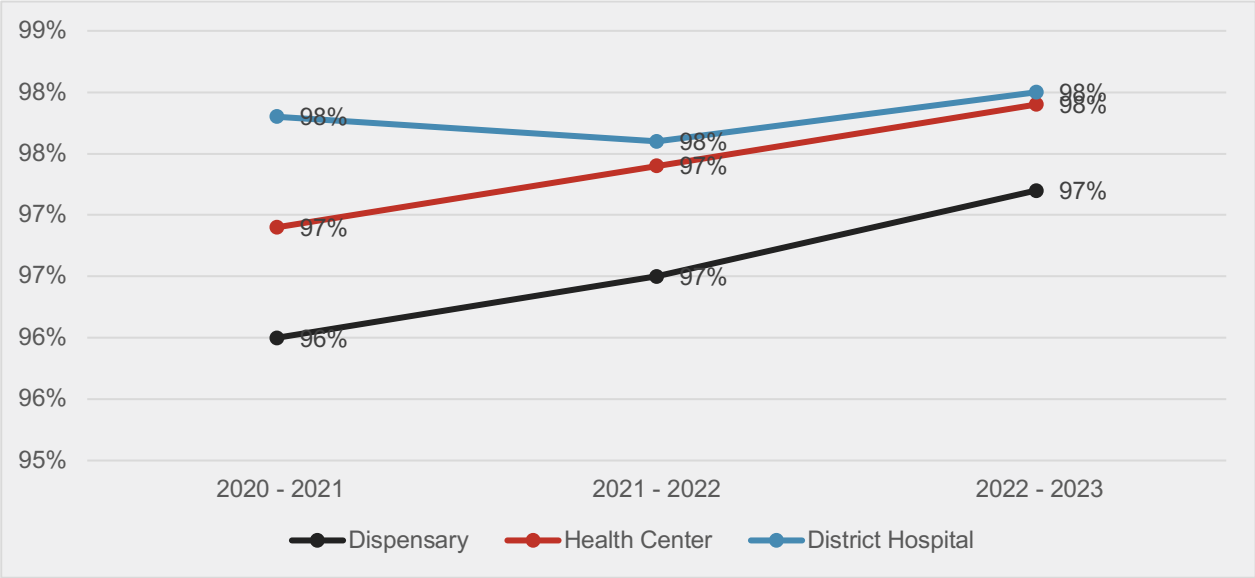


Source: MoH – DHIS2

3.6.7 Percentage of Institutional Deliveries

In 2020/21, the percentage of institutional deliveries was reported at 96% in dispensaries, 97% in health centres, and 98% in hospitals (Figure 16). By 2022/23, the rates had increased to 97% in dispensaries and 98% in health centres, while the percentage for hospitals remained unchanged at 98%.

Figure 16: Percentage of Institutional Deliveries



Source: MoH – DHIS2

3.7 Equity and HBF Allocation Formula

Health expenditures in mainland Tanzania vary considerably both between and within regions (World Bank, 2020). The Health Basket Fund allocates funds according to a formula that is partially influenced by demographic and equity considerations. However, this formula is not applied to budget allocations or the distribution of human resources, which represent a significant portion of total costs. The World Bank report highlights that the challenge of recruiting healthcare personnel willing to work in remote and economically disadvantaged areas exacerbates the inequitable distribution of resources.

The HBF allocation formula follows a capitation-based approach, incorporating risk adjusters to account for healthcare needs. These are proxied by population size, disease burden (measured by under-five mortality), and equity considerations (reflected by poverty incidence and capped land area) (MoH, 2020; Mtei et al., 2023). The 5th Edition of CCHP guideline released in 2020 updated the allocation formula to accommodate the health-sector financing reforms such as DHFF and ensuring equity (MoH, 2020; MoHCDGEC & PO-RALG, 2017). The basis for resource allocation to councils includes population (60%), poverty (10%), under-five mortality (10%), and capped land factor (20%) (MoH, 2020).

The allocation ceiling for primary healthcare facilities also considers the utilisation of health services and overall performance. Whereas allocations for council hospitals is determined based on the workload and performance of the respective facilities, the allocation for dispensaries and health centres (30% and 25% respectively) is amalgamated to create a pool for lower-level health facilities. Parameters employed for the allocation to health facilities include: catchment population

- 40%; distance of the individual dispensary/health centre to the council's headquarters - 10%; service utilisation - 40%; and performance - 10% (MoH, 2020).

The allocation does not consider the staffing, which is unevenly distributed across the councils and regions in the country. The Human Resource for Health Tanzania Mainland Country Profile 2023 showed that the health sector has 1 doctor per 8,882 people and 1 nurse per 1,289 people, which is significantly less than the WHO recommendation of 439 doctors, nurses, and midwives per 10,000 people (URT, 2023d). The health workforce was normally distributed across the ten regions, except for a higher proportion (16.21%) in the Dar es Salaam region. This is due to the presence of a large number of higher-level hospitals. The Geita (1.21), Simiyu (1.78), Katavi (0.96), Ruvuma (2.8), Manyara (2.33), Kigoma (3.132), and Singida (2.49) regions had relatively fewer health workers. Of all cadres, 55,705 (46.55%) of the health workforce were found in rural settings and 63,973 (53.45%) were in urban settings. Of all doctors, 71.50% (4,791) were located in urban areas and 28.50% (1,910) in rural areas. However, nursing professionals located in rural areas numbered 22,841 (49.49%) and those in urban areas numbered 23,315 (50.51%) (URT, 2023d).

A recent study highlights the importance of promoting equity and efficiency in health financing across Tanzania's 26 regions to advance progress toward UHC. The analysis revealed significant disparities in per capita health funding, particularly in insurance contributions, which ranged from TZS 473 to TZS 13,520 per person (Binyaruka *et al.,* 2024). In contrast, allocations from the HBF were more balanced, ranging between TZS 1,294 and TZS 2,394 per person. Financial protection was also relatively high across all regions, with between 93.5% and 99.4% of households not incurring catastrophic or impoverishing health expenditures - indicating that only a small fraction of the population faced significant financial hardship due to out-of-pocket healthcare costs.

The study further assessed the fairness of health resource distribution using the Kakwani Index. Government spending showed only a weak and statistically insignificant relationship with regional economic need (KI: -0.047, $p = 0.348$), indicating limited targeting of poorer areas. In contrast, HBF spending was significantly progressive (KI: -0.195, $p < 0.001$), meaning it was more equitably distributed, with a greater share directed to economically disadvantaged regions. Regarding efficiency, the average regional score was 90%, suggesting that the majority of financial resources were used effectively, while an estimated 10% were either underutilized or inefficiently spent.

3.8 Health Workforce and Incentive Structures

3.8.1 Overview of HRH Composition and Distribution

Tanzania continues to face persistent shortages and maldistribution of health workers, particularly at the PHC level. The National Health Policy stipulates that the government will strengthen capacity at various levels through the implementation of a comprehensive human resource development plan. This plan aims to support the deployment and retention of well-trained and motivated personnel at the appropriate levels of health service delivery (URT, 2007a). According to the Ministry of Health's Human Resource for Health Strategic Plan (2021–2026), the national health system operates with less than 60% of its required workforce, with the deficit most severe in rural and hard-to-reach areas (MoH, 2021).

At the dispensary level, many facilities operate with fewer than three staff members, often requiring lower-qualified cadres or staff from other professions to take on multiple clinical and administrative responsibilities. Health centres, while better staffed, often struggle to attract and retain specialized personnel such as laboratory technicians, midwives, and clinicians with surgical capacity.

Tanzania, similar to other developing nations, is experiencing a significant shortage of healthcare personnel. As per the recent staffing level guidelines for the financial year 2022/23[2], the health sector requires a minimum of 348,923 health workers to adequately deliver services. However, only 119,678 health workers are currently available in healthcare facilities, representing just 34% of the needed workforce. The primary healthcare system exhibits the most substantial gap in human resources compared to other levels of care (Table 5).

Table 5: Requirement and availability of Heath Care Workers

Level of care	Requirement	Available	Gap	% Available	% Gap
Dispensaries	100,646	30,625	70,021	30	70
Health Centres	68,204	25,354	42,850	37	63
District councils	123,624	29,409	94,215	24	76
Regional Referral Hospitals	16,324	11,664	4,660	71	29
National, specialized and zonal hospital	27,941	18,528	9,413	66	34
Health Training institutions	2,637	956	2,682	36	64
MDAs/Parastatals	9547	3142	6405	33	67
	348,923	119,678	230,246	34	66

Source: Human Resource for Health, Tanzania Mainland Country Profile, MoH 2023

The current staffing levels are significantly below the international benchmarks set by the World Health Organization regarding the ratio of healthcare professionals, including physicians, nurses, and midwives, to the population. The national average stands at 8.4 healthcare workers per 10,000 people, which is only one-third of the World Health Organization's recommended standard of 22.8 healthcare workers per 10,000 individuals (MoH, 2023b). The disparities on the staffing level affects very much the performance of some of the facilities in the region.

> "*We are two people doing everything - treating, cleaning, reporting, supervising. We even buy our own stationery to prepare reports*." (Dispensary In-charge, Southern Highlands, Field Interview).

> "*Staffing levels are not equal. Some health centres have more trained staff, but others are relying on community health workers or assistant nurses*." (RHMT Representative, Lake Zone, Field Interview).

3.8.2 HBF Support to HRH and Incentives

The HBF is not designed to cover salaries for civil servants, which remain the responsibility of the central government. However, it plays a vital complementary role in supporting workforce motivation, retention, and operational performance. Key activities funded under HBF include:

- In-service training and refresher courses
- Supervision allowances and per diem

[2] Human Resource for Health, Tanzania Mainland Country Profile, MoH 2023

- Performance incentives for outreach activities
- Support for accommodation or hardship allowances in selected councils

Despite these provisions, several councils reported inconsistent or suboptimal use of HBF resources for HRH-related activities. For instance, supervision funds are often depleted quickly due to high transportation and fuel costs, limiting capacity for effective coaching or follow-up mentoring.

> "*Most of our health workers don't get regular training. The budget is limited and usually spent on planning meetings*." (CHMT Member, Central Zone, Field Interview).
>
> "*Supervision is seen as a visit, not as a learning opportunity. We lack funds for proper follow-up or mentoring."* (Health Centre Supervisor, Northern Zone, Field Interview).

Hospital-based staff voiced additional concerns about the reliability and adequacy of performance-based incentives. In some regions, payments had been delayed for multiple quarters, and when paid, were seen as insufficient relative to workload, particularly in maternal and emergency services.

> *"They ask us to reduce maternal deaths but won't pay overtime. We stay out of duty, not reward."* (Nurse-midwife, referral hospital, Southern Highlands Zone, Field Interview).
>
> At a strategic level, Development Partners raised concerns about the fragmented and sometimes ad hoc use of HBF for staff incentives. Several questioned the long-term viability and equity implications of using basket resources for top-up allowances, warning that without alignment to broader HRH reform, such incentives could distort staff motivation and create disparities between councils or programs. *"Incentives through HBF must be harmonized or phased out - this isn't scalable."* (KII DP representative, Field Interview).

Some Development Partners advocated for a more structured, nationally guided incentive framework, recommending that HBF-funded incentives be limited to well-defined, scalable models, linked either to rural deployment challenges or verified performance metrics within an integrated HRH strategy.

3.8.3 Challenges in Supervision and Task Allocation

Supervision of PHC facilities is formally organized through CHMTs and supported by regional health teams. However, at operational level, health centres are assigned supervisory and administrative support roles for surrounding dispensaries, especially in remote areas. This decentralized arrangement is not consistently formalized or funded.

- Health centres frequently assist with coding, budgeting, and reporting on behalf of nearby dispensaries lacking administrative staff.
- Dispensary in-charges remain responsible for final validation and compliance with reporting standards, placing a heavy burden on their time and capabilities.

> "*We rely on our referral health centre to help us submit PlanRep and FFARS entries. But the in-charge is still held accountable*." (Dispensary Staff, Western Zone, Field Interview).

This creates potential vulnerabilities in accountability and undermines the efficiency of task

Rural dispensaries frequently reported prolonged gaps between CHMT supervision visits, sometimes over a year, due to transport and budget constraints. This affected adherence to DHFF

guidelines and demoralized staff. Urban dispensaries received more regular visits, sometimes combined with trainings, though still noted short durations and limited feedback.

> *"Our last supervision was 2022. We learn from trial and error."* (Facility In-charge, rural dispensary, Western Zone, Field Interview).

3.8.4 HRH Incentive Gaps and Policy Constraints

The incentive environment at the PHC level remains inconsistent and dependent on LGA discretion. Although certain districts introduce local non-financial incentives (e.g. housing support or promotion priority), these are not systematically linked to performance or service delivery needs.

A number of systemic constraints were identified:

- Lack of standardized guidance on performance-based incentives under HBF.
- No earmarked funding line in the HBF for health worker hardship allowances.
- HRH allocation decisions (e.g. new postings) are driven by national quota systems, often disconnected from local staffing realities.

> "*We requested two more nurses, but we are told to wait for the central HRH allocation. Meanwhile, the workload increases*." (CHMT HR Officer, Eastern Zone, Field Interview).

Experts pointed out that although HBF guidelines allow for performance-based incentives, the scale is inadequate to meaningfully influence motivation or staff retention - especially in underserved and remote areas. They emphasized that the HBF cannot serve as a substitute for a comprehensive national health workforce incentive policy. Fragmented expectations around HBF-based rewards may inadvertently demotivate staff if they are not backed by sustainable frameworks.*"You're rewarding with teaspoons what you're demanding with shovels." (*Health Financing Expert, Field Interview).

3.8.5 Equity Issues in HRH Deployment

Interviews and analysis of staffing data revealed that high-performing or urban-adjacent councils tend to attract more qualified staff due to:

- Better living conditions and transport infrastructure
- Proximity to training institutions
- Higher likelihood of donor-funded projects or supplementary allowances

By contrast, hard-to-reach councils suffer double disadvantage - limited infrastructure and fewer incentives to attract skilled personnel. This contributes to the equity gap in service provision despite equal or greater need in those areas.

Both rural and urban health centres face distinct human resource challenges. Rural facilities continue to experience acute staffing gaps, particularly in laboratory services and midwifery. In-charges reported long-standing vacancies and cases where newly posted staff quickly left due to remoteness or lack of incentives. Urban health centres, while generally better staffed, reported high patient loads leading to staff burnout and highlighted a lack of administrative support personnel as a contributing factor.

> *"They posted a lab technician, but he left after 3 weeks—too remote, no incentive."* (Facility In-charge, rural health centre, Southern Highlands Zone, Field Interview).

3.9 Integration with Health Insurance and UHI Reforms

3.9.1 Policy Framework and UHI Reform Context

In 2024, the Government of Tanzania enacted the UHI Act, marking a pivotal reform in the country's health financing landscape. The Act aims to integrate the NHIF and the iCHF into a unified scheme. The reform intends to enhance financial protection, reduce out-of-pocket expenditure, and expand coverage to exempted and vulnerable groups, including the poor, elderly, pregnant women, and children under five (URT, 2023a).

The UHI reform is intended to shift Tanzania towards mandatory health coverage, eventually replacing fragmented risk pools and introducing subsidized community insurance packages (CHIP) for low-income populations. However, this transition introduces a new layer of complexity for health financing mechanisms like the HBF, which currently supports large segments of the population that may later be covered under the UHI.

> "*We don't yet know how the UHI package will work at facility level. Will it pay for everything the Basket covers now*?" (NHIF Official, National Level, Field Interview).

3.9.2 HBF as supply side and UHI as demand side

In attesting to the extent to which the management and functionality of the HBF are compatible and harmonised with other health financing reforms, many HBF DPs and health financing experts expressed the view that the implementation of the UHI would not adversely affect the operations of the HBF. They described the two mechanisms in terms of a "supply side–demand side" division:

"…. for me, that's more to demand and supply because basket funds support the provision of services and the implementation of health insurance. This means they will purchase and support these services. They still have basket funds, so it is similar to being parallel to basket funds; they are strengthening the provision of services and health insurance to procure the services that are already supported through basket funds." (Ministry of Health, Field Interview).

> "…. *The health insurance is intended for service delivery demand side. When considering the basket fund, there is significant investment not only supply side, but also in improving facilities, constructing infrastructure, and enhancing theatres. The basket fund supports many initiatives beyond just service delivery*." (KII, DPs representative, Field Interview).

> "*As I mentioned earlier, the basket fund will remain relevant in the context of UHI. The health basket fund is the money allocated to support service delivery to facilities, regardless of insurance coverage. Facilities will receive guaranteed resources to ensure they can provide services. Therefore, I don't see a threat to the basket fund due to the introduction of UHI. UHI is intended to complement the initiatives that have been in place for quite some time*." (KII, Health Financing Expert, Field Interview).

While this framing reflects common stakeholder perceptions, it risks oversimplifying the intended operational model. In practice, facilities should prepare a **single, comprehensive annual activity plan** with a corresponding **integrated budget** that consolidates all revenue sources - including HBF allocations, UHI reimbursements, and other government or donor transfers. This approach allows managers to flexibly allocate resources across promotive, preventive, curative, and administrative priorities according to local needs, without being constrained by the origin of the funds. Under such an integrated model, UHI revenues are not inherently restricted to curative care but can also support preventive services, outreach, infrastructure upgrades, or staff incentives, provided national guidelines permit this flexibility. The challenge is therefore to adjust policies and expenditure rules so that both HBF and UHI flows can be planned, disbursed, and accounted for in a harmonised way.

This integration requires deliberate policy change: under current practice, facilities must tag each activity to a specific funding source in PlanRep, and different ceilings and restrictions apply to each. These source-based rules can unintentionally skew UHI funds toward curative services. Removing or harmonizing such restrictions will allow UHI revenues to contribute to the full spectrum of PHC priorities, as envisaged in the comprehensive planning model.

3.9.3 Role of HBF in Bridging the Transition

The HBF currently plays a vital role in funding services for exempted groups and non-insured populations, especially in rural and hard-to-reach areas. As UHI is scaled up, the HBF's role may shift from direct financing of recurrent inputs to co-financing non-insurable services and quality improvement activities, such as:

- Preventive and promotive services (e.g. immunization, community outreach)
- Infrastructure maintenance and utilities
- Training and supervision
- Emergency referral and ambulance services

This shift requires strategic alignment to avoid duplication, ensure continuity of care, and protect the core PHC functions during the transition phase. While stakeholders often anticipate that UHI reimbursements will mainly finance curative services, facility-level integrated planning should allow these revenues to also support preventive, promotive, and quality-improvement activities where permitted, alongside HBF and other funding streams.

> "*Right now, HBF pays for most of the day-to-day costs. If UHI comes in, we don't want to lose flexibility for essential services*." (Council Health Planning Officer, Southern Highlands, Field Interview).

"*The insurance will pay for services, but not for outreach or training. That's where HBF is still needed*." (CHMT Member, Lake Zone, Field Interview).

3.9.4 Institutional and Operational Linkages

Current integration between the HBF and health insurance mechanisms (NHIF, iCHF) remains limited. Facilities that receive both HBF and insurance reimbursements must navigate:

- Separate reporting systems, with health insurance using their own billing software and claims procedures
- Disparate planning cycles and funding schedules
- Different allowable expenditure categories, with HBF bound by earmarking ratios

The operational disconnect has created fragmented financial management at facility level and imposed parallel administrative workloads, especially in areas where UHI rollout has started.

Nonetheless, digital systems such as GoTHOMIS, AfyaCare, and openIMIS (used by iCHF) present a strong foundation for future integration, but also pose challenges.

> "*We input data in both GoTHOMIS and NHIF systems, and now iCHF has its own platform. It's triple work*." (Health Facility Accountant, Central Zone, Field Interview).

From a strategic perspective, Development Partners voiced concern that integration between the HBF and the UHI framework lacks a clear operational and financing roadmap. While UHI reforms rightfully command political visibility, there is a growing risk that HBF - despite its central role in

strengthening supply-side readiness - may be institutionally sidelined unless protected and purposefully aligned.

> *"If HBF is the engine of PHC, UHI should be the steering system. Both must be aligned."* (KII Development Partners, Field Interview).

These observations underscore the need for stronger institutional coordination and clearer articulation of the complementary roles of demand- and supply-side financing mechanisms within Tanzania's health financing transition.

3.9.5 Financing Implications and Risks

A major concern raised by stakeholders is whether the UHI will generate sufficient and timely reimbursements to sustain PHC operations, particularly for formerly exempted groups. There is uncertainty around:

- The level of premium subsidies for poor households under UHI
- Whether UHI reimbursements will match or exceed current HBF contributions
- How to coordinate budgeting across the two mechanisms to avoid funding gaps

> "*If UHI doesn't reimburse us quickly, and HBF reduces, how will we buy medicine or pay for outreach*?" (Dispensary In-charge, Western Zone, Field Interview).

While international experience shows that many insurance schemes focus heavily on curative care, this is not a structural necessity. Under Tanzania's UHI, reimbursements - when integrated with HBF and other public allocations - should finance a comprehensive, approved facility plan that includes preventive, promotive, curative, and administrative functions.

3.9.6 Opportunities for Strategic Harmonization

The ongoing UHI reform presents an opportunity to position the HBF as a strategic co-financer of PHC within Tanzania's existing integrated planning framework. Currently, all public facilities prepare a single annual work plan and budget through PlanRep, linked to FFARS for execution and reporting. However, these plans must indicate the funding source for each activity, and facilities face varying restrictions, earmarks, and thresholds depending on the source. This reduces flexibility to reallocate resources to emerging priorities and creates inefficiencies when funds are tied to narrowly defined uses.

To address this, national policy makers and financing partners should systematically review and, where feasible, harmonize or remove restrictive expenditure rules that prevent optimal use of combined resources. While certain ring-fenced or programme-specific funds will remain necessary, clearer national guidance could define conditions under which facilities may reallocate across funding lines, especially when doing so would improve service delivery or address urgent needs.

The **revival and completion of the National Health Financing Strategy** offers a key platform to define these harmonization principles, clarify the complementary roles of HBF and UHI, and set medium-term targets for integrating financing flows at the point of service. The strategy should also outline how expenditure flexibility can be balanced with accountability, ensuring that both earmarked programme priorities and local operational needs are met.

Specific opportunities for harmonization include:

- **Gap-filling for non-covered services** under UHI, especially preventive and promotive interventions.

- **Pooled procurement and logistics** to achieve economies of scale.
- **Joint financing of quality improvement measures**, including supervision and performance monitoring.
- **Equity-sensitive allocation adjustments** for underserved and hard-to-reach areas

A sequenced transition plan - embedded in the National Health Financing Strategy - should ensure predictable financing commitments, harmonised reporting systems, and integrated financing data. This will minimise duplication, reduce administrative burden, and protect the full scope of PHC functions during UHI rollout.

> "*We need a roadmap for how HBF and UHI will work together. Otherwise, we risk confusion at the facility level*." (KII, DPs representative, HBF Steering Committee, Field Interview).

3.10 Reporting Systems and Administrative Workload

This section assesses the planning, budgeting, and reporting processes under the HBF, focusing on administrative workload and system integration challenges at council and facility levels. It draws on findings from the document review, KIIs, FGDs, and prior evaluations such as Piatti-Fünfkirchen & Schneider (2018), Mæstad et al. (2021), and Maiba et al. (2023).

3.10.1 Overview of Planning and Budgeting Processes

Planning in Tanzania follows a bottom-up exercise in which health facilities develop annual plans to deliver activities and achieve specific outputs and outcomes, such as vaccination coverage. These plans are submitted to district authorities, who collate and forward them to the legislature for approval.

However, facility plans often tend to be overly ambitious and are subsequently adjusted by administrators to conform to budget ceilings established only after the planning phase (Piatti-Fünfkirchen & Schneider, 2018). These adjustments occur without adequate consultation with facility-level actors, leading to a misalignment between planned activities and available budgets. Facilities are not given the opportunity to reprioritize their plans once actual budget ceilings are finalized. This undermines the purpose of bottom-up planning and may be compounded by administrative inefficiencies from staff unfamiliar with facility-level needs making allocation decisions on their behalf.

> "*We plan based on needs, but in the end the budget comes and decisions are changed without us. Sometimes we implement activities we didn't even prioritize*." (Health Facility In-Charge, Northern Zone, Field Interview).

Planning, budgeting, and reporting at the district level have also benefited from the introduction of digital solutions. Nonetheless, the HBF process remains predominantly characterized by a top-down and rules-based approach to budgeting and expenditure decisions, requiring strict adherence to pre-established protocols (Maiba et al., 2023).

3.10.2 Community Governance and Facility Involvement

The HBF initiative has played a key role in strengthening community-level governance. Notably, there has been an increase in the frequency of meetings of HFGCs, along with greater involvement of these bodies in budgeting and expenditure decisions (Mæstad et al., 2021; URT, 2023e). These developments have enhanced the committees' influence on facility operations and helped establish a form of mutual accountability between facilities and district authorities.

Funding from the HBF is also used to pay allowances to HFGC members for attending meetings, further incentivizing their active engagement. Improved transparency in the allocation of funds has helped build trust between providers and district managers and has reduced tensions within local health systems. However, some district-level managers have expressed concern about the loss of direct control over certain financial decisions (Mæstad et al., 2021).

3.10.3 Digital Reporting Systems and Complexity

The introduction of DHFF has empowered facilities to directly manage resources from various sources. However, it has also introduced a complex landscape of planning, reporting, and accounting responsibilities.

Health facilities must interact with several digital platforms and paper-based reporting formats, including:

- **FFARS** - Tracks financial transactions, expenditures, and reconciliations.
- **PlanRep** - Used for planning and budgeting in alignment with the CCHP cycle.
- **GoTHOMIS** - Captures service delivery and clinical information at the facility level.
- **NHIF and iCHF systems** - Manage claims processing and insurance reimbursements.
- **PforR systems** - Operate independently with unique templates and validation procedures.

While some of these systems are technically linked through the Muungano Gateway (URT, 2022a; Kuwawenaruwa *et al*., 2023), most require duplicate manual data entry and reconciliation due to non-standardized fields and weak integration.

> "*We are told to report through FFARS, PlanRep, GoTHOMIS, and still prepare paper files for PforR audits. It is too much*." (Dispensary In-Charge, Southern Highlands, Field Interview).

> "*If PlanRep is not updated, you cannot align budgets. But FFARS doesn't automatically feed into PlanRep. We have to do it manually*." (CHMT Accountant, Central Zone, Field Interview).

While hospitals had comparatively better digital infrastructure than lower-level facilities, staff still reported that FFARS and PlanRep posed an administrative burden. Senior medical officers and accountants cited duplication of reporting and limited feedback from higher levels after submission. This created a perception of compliance over utility.

> *"We upload everything - but nobody comes to discuss the data."* (Health Secretary, urban hospital, Coastal Region, Field Interview).

3.10.4 Administrative Burden and Capacity Constraints

The administrative workload at the PHC level is particularly heavy. Most dispensaries lack dedicated administrative staff, and responsibility for planning, accounting, and reporting falls on clinical staff - usually the in-charge - who must balance these tasks with service delivery, patient care, and outreach.

> "*One person is expected to provide care, supervise staff, and also do all the paperwork. It's not realistic*." (Health Centre In-Charge, Western Zone, Field Interview).

While some health centres offer administrative support to dispensaries, this practice is inconsistent and rarely formalized. Moreover, many health centres also suffer from personnel shortages and lack designated accountants.

> "*Even when the system is digital, we still need to print, sign, scan, upload, and submit to multiple stakeholders*." (CHMT Member, Northern Zone, Field Interview).

FFARS and PlanRep have improved transparency, but many dispensaries, especially rural, face practical challenges in using them effectively. Limited digital literacy among staff, lack of stable internet, and frequent power cuts impede real-time data entry. In some rural councils, digital infrastructure remains inadequate, making it difficult to operate PlanRep and FFARS consistently. Facility in-charges reported recurring outages, lack of IT support, and insufficient training, which directly hinder timely budget execution and performance reporting.

> *"If the computer breaks down, there's no one to fix it. We just wait or report late."* (Facility In-Charge, Rural Health Centre, Southern Highlands, Field Interview).

Urban facilities reported better connectivity, but still raised concerns about increased administrative burden on clinical staff.

> *"I deliver a baby in the morning and upload PlanRep at night. There's no break."* (Facility In-charge, rural dispensary, Southern Zone, Field Interview).

CHMTs frequently cited the heavy workload related to supervising digital planning, financial reporting, and performance tracking. With increasing reporting complexity across PlanRep, FFARS, and DHIS2, some councils reported more time spent on data cleaning than actual supervision or mentoring.

> *"We supervise computers, not facilities."* (CHMT member, rural district, Northern Zone, Field Interview).

> *"The system assumes stable internet and electricity, which we don't have."* (CHMT Accountant, rural district, Southern Zone, Field Interview).

3.10.5 Donor Coordination and System Fragmentation

Development Partners contributing to the HBF have tried to align their reporting requirements with national systems. However, vertical programs (e.g. for immunization or HIV/AIDS) often maintain their own formats and data structures. This creates inconsistencies, duplication, and interoperability issues between platforms.

> "*We get asked to verify conflicting numbers from different systems. But we're just receiving the reports - we didn't input them*." (CHMT Planner, Lake Zone, Field Interview).

Efforts to consolidate PforR and insurance reimbursement reporting into a single system have not yet succeeded due to differences in data formats and accountability frameworks.

3.10.6 Opportunities for Streamlining

Despite these challenges, digitization presents clear opportunities to improve efficiency. The following areas offer potential for immediate gains:

- Deepen the integration of **FFARS**, **PlanRep**, **GoTHOMIS**, and **insurance systems**.
- Standardize **expenditure coding procedures** across funding streams.
- Deploy **shared administrative staff** or **mobile accounting support units** to service clusters of facilities.

- Expand **targeted training** for facility staff - particularly at the dispensary level - in digital reporting tools. Streamline vertical programme systems reporting with FFARS, PlanRep GoTHOMIS and others.

"*If FFARS and PlanRep could sync, we'd save hours of duplicate work every month."* (Regional Planning Officer, Southern Zone, Field Interview).

"*The government is trying, but facilities urgently need personnel and tools to manage the new systems."* (Development Partner, HBF Committee, Field Interview).

3.11 Monitoring, Supervision, and Performance Frameworks

3.11.1 Overview of the HBF Performance Framework

The Health Basket Fund has adopted a results-oriented approach through the introduction of a comprehensive performance framework that informs fund allocation and disbursement. The current framework consists of a scorecard-based system that tracks performance indicators across central, regional, and council levels, with weighting of indicators influencing the funding received by LGAs.

Performance indicators include key service delivery metrics such as:

- Institutional deliveries and maternal health services;
- Coverage of priority disease interventions (e.g., malaria, TB);
- Infrastructure improvements and staff availability;
- Availability of essential medicines;
- Financial accountability and timely reporting.

A total of 20 performance indicators are used across levels, as outlined in the HBF Operational Manual (2021 - 2026). These indicators are reviewed annually through the IAG performance report, which serves as a prerequisite for the signing of side agreements between DPs and the Government of Tanzania - a step that unlocks fund disbursement.

> "*The IAG report drives the funding schedule. If it's delayed, everything stalls*." (MoH Official, Central Level, Field Interview).

Moreover, the institutional delivery indicator relies on the number of women utilizing antenatal care (ANC) services at a designated facility, as well as the demographic of women of reproductive age within that facility's catchment area. Some women may choose to access ANC at one facility but then opt for a different location for delivery. This decision affects the targeted delivery rates at the facility where ANC was received. A situation similar to that observed in Arusha has also been documented in Iringa, underscoring the need to re-evaluate the institutional delivery indicator. While certain facilities serve a large catchment population and receive many ANC visits, women often prefer to deliver at alternative locations, including those outside their council or region.

> "…. *But there is a certain indicator of institutional delivery. They look at the entire population in general, particularly those who should give birth at health centres. Our council has a large population compared to the number of women who give birth at the facilities; hence, reaching 100% becomes impossible because some mothers choose to give birth in other councils, and others even travel to Morogoro or Mlimba. Consequently, we have fewer mothers giving birth in our council compared to those in the town. When a*

mother leaves to give birth elsewhere, she is counted there. This results in the facility showing higher numbers of deliveries while we are left with a low number. This indicator is what is troubling us. Therefore, I suggest that we consider the number of facility deliveries and the people who attended the clinic; if eight people attended, we would expect those eight to have given birth. …." (KII, Southern Highlands Zone, Field Interview).

"Some indicators are not fully within our control, but still affect our funding." (CHMT Member, Southern Zone, Field Interview).

3.11.2 Supervision Structures and Responsibilities

Supervision under the HBF occurs at multiple levels and is coordinated primarily by CHMTs and RHMTs. Supervision responsibilities include:

- Verifying facility performance reports;
- Providing technical support to facilities;
- Monitoring adherence to service delivery and financial standards;
- Following up on DHFF and PforR implementation.

Importantly, health centres are expected to provide administrative and supervisory support to assigned dispensaries in their vicinity. This includes support in preparing financial reports, interpreting budget codes, and ensuring that health service data aligns with expenditure records.

"*We help our linked dispensaries with FFARS reporting and coding, since they don't have an accountant."* (Health Centre Accountant, Western Zone, Field Interview).

However, in practice, this role is inconsistently applied due to:

- Absence of dedicated accounting staff at health centres;
- Lack of transport and logistical means for regular supervision;
- Inadequate supervision budgets at CHMT level.

"*Sometimes we only go once a quarter - there's no fuel or vehicles. Supervision is on paper*." (CHMT Supervisor, Lake Zone, Field Interview).

Hospitals reported fragmented and overlapping supervision from CHMTs, RHMTs, and vertical programs. Some rural hospitals received repeated visits within a short span—focused on data compliance—while lacking clinical mentoring. Others highlighted that annual supervision does not align with DHFF implementation needs.

"Everyone comes with a checklist. But who helps us solve the problem?" (Medical Officer in-charge, rural hospital, Central Zone, Field Interview).

CHMTs and RHMTs reported irregular funding for supervision activities, often resulting in tokenistic or checklist-style visits. Supervision was often dictated by vertical program needs (e.g., immunization, HIV) rather than local quality gaps. RHMTs flagged the lack of joint supervision strategies and limited integration across funding streams.

"Supervision today means printing a form and signing it." (Health Officer, CHMT rural district Central Zone, Field Interview).

"There's no time or transport to support quality improvement." (RHMT Representative, Lake Zone, Field Interview).

3.11.3 Performance-Based Allocation and Its Impacts

The performance-linked allocation mechanism of the HBF incentivizes accountability and service improvements but has also led to unintended consequences:

- Facilities and LGAs with lower baseline capacity are disadvantaged in funding despite often facing more difficult conditions.
- Performance measurement is often heavily weighted on clinical service indicators, leaving preventive, promotive, and administrative aspects underrepresented.
- Facilities often lack feedback mechanisms to understand their performance scores or adjust in real time.

"*They tell us the score after the funds are decided. But by then, we can't change anything*." (Dispensary In-charge, Eastern Zone, Field Interview).

"*Preventive services like outreach don't count for much, but they're the core of our work*." (Health Centre Officer, Central Zone, Field Interview).

3.11.4 Data Quality and Verification Challenges

Supervision teams often identify inconsistencies between reported service data and facility-level records, driven by:

- Manual record keeping in some facilities;
- Limited training in indicator interpretation;
- Pressure to report high performance for funding incentives.

These challenges raise concerns about data reliability and the effectiveness of performance-based financing (PBF) as a sustainable mechanism.

> "*Sometimes you report what looks good, because funding depends on it*." (Facility In-charge, Northern Zone, Field Interview)

Efforts are underway to strengthen data verification procedures, including integration of GoTHOMIS and DHIS2, and triangulation of financial and service delivery data.

3.12 Community Participation and Governance Mechanisms

In addition to institutional supervision mechanisms, community oversight plays a vital role in ensuring transparency and local accountability in HBF implementation.

3.12.1 Framework for Community Engagement

Community participation in health governance is a core pillar of Tanzania's decentralization by devolution (D-by-D) policy. The HBF has supported this principle by embedding community structures into planning and oversight processes. Two main structures have been institutionalized:

- **Health Facility Governing Committees (HFGCs)**: Established at all dispensaries and health centres, composed of community representatives, health workers, and local leaders. Their mandate includes reviewing facility plans, endorsing budgets, overseeing use of HBF funds, and mobilizing community engagement in health promotion.

- **Council Health Service Boards (CHSBs)**: Established at the council level, overseeing the overall health sector performance within the district. They review and approve the CCHP, and supervise CHMT operations in collaboration with RHMTs.

"*Our HFGC meets every quarter, and we go through the budget line by line. It's our responsibility*." (HFGC Member, Coastal Region, Field Interview).

The legal mandate of these structures is outlined in the Public Health Act and the Local Government Acts. Under the DHFF framework introduced in 2017/18, HFGCs were empowered to directly review and approve their facility's expenditure plans, a significant step in deepening bottom-up accountability.

3.12.2 Functionality of Governance Structures

While Health Facility Governing Committees (HFGCs) and Council Health Service Boards (CHSBs) are formally established across councils and regions, their actual functionality varies considerably. The Mid-Term Review (MTR) identified several enabling and limiting factors that influence the performance of these governance structures:

Enabling Factors:

- Capacity building through orientation and training supported by development partners;
- Regular access to FFARS and PlanRep data by facilities and HFGCs;
- Strong leadership commitment at the facility level fostering a culture of participation.

Limiting Factors:

- Low levels of financial literacy among HFGC members, especially in remote areas;
- Lack of transport or per diem support, which discourages attendance at meetings;
- Inconsistent communication from facility in-charges to committee members;
- High turnover of committee members without corresponding re-training.

  "*Sometimes the in-charge just tells us what was spent. We don't always get the documents*." (HFGC Member, Western Zone, Field Interview).

  "*When members change, there is no training. It takes a long time before the new ones understand the work."* (Dispensary In-Charge, Lake Zone, Field Interview).

Analysis of HFGC meeting frequency revealed mixed patterns. While some facilities held quarterly meetings as expected, others convened only once during the past year - or not at all. Dispensary-level HFGCs exhibited the greatest variability. Urban facilities were generally more active, benefiting from closer proximity to council offices and greater exposure to training opportunities. In rural areas, participation was often constrained by lack of orientation and persistent frustrations - especially when planned activities could not proceed due to funding delays or spending restrictions.

> *"We meet, we plan, but when no money comes, people stop showing up."* (HFGC Chairperson, rural dispensary, Southern Highlands Zone, Field Interview).

Hospital Health Boards also displayed divergent levels of functionality. Urban hospitals often held meetings more regularly, supported by politically influential or technically engaged board members. In contrast, rural hospital boards were less consistent, with some reporting limited involvement in financial or strategic planning. Many hospital leaders expressed a need for clearer operational guidelines and tailored training for board members.

"Our board meets, yes - but it's more ceremony than strategy." (Hospital In-charge, regional hospital, Northern Zone, Field Interview).

3.12.3 Community Voice and Social Accountability

The presence of HFGCs is intended to link the community's voice with facility operations, offering a channel for grievances, suggestions, and community health priorities. However, meaningful community engagement remains inconsistent:

- HFGCs often lack formal mechanisms to collect input from the broader community;
- Complaint and suggestion boxes were found in less than 50% of visited facilities;
- Community feedback loops - where complaints lead to actionable response - are rare;
- Most HFGCs function more as compliance mechanisms than advocacy bodies.

"*The community doesn't really know who we are or what we do in the HFGC."* (HFGC Chairperson, Southern Highlands, Field Interview).

These gaps reduce the accountability potential of the HBF and weaken trust in facility governance. Where properly supported, however, HFGCs have played a pivotal role in improving transparency, especially in relation to procurement, facility infrastructure improvements, and patient satisfaction monitoring.

3.12.4 Integration into Planning and Budgeting

Under the DHFF and CCHP frameworks, community participation in annual planning is a stated requirement. PlanRep allows health facilities to upload their proposals, which are then consolidated at the CHMT level and approved by the CHSB.

The MTR observed that:

- In some LGAs, HFGCs actively participate in planning sessions and contribute to priority setting;
- In other councils, facility plans are prepared by the in-charge alone, with minimal input from HFGC members.

The degree of integration often correlates with the availability of training and mentoring - suggesting that continued investment in capacity building for HFGCs is essential.

"*The CCHP process is very technical. HFGC members are consulted late or not at all."* (CHMT Member, Northern Zone, Field Interview).

HFGC involvement in planning is present at most health centres, with urban facilities better equipped for structured engagement. Many rural HFGCs cited challenges understanding PlanRep outputs or engaging with FFARS data, often relying on facility staff to interpret budget lines. Still, commitment to involvement was strong across locations.

"People expect us to act like a board, but we've never had a single session on budgeting." (HFGC Chairperson, rural health centre, Central Zone, Field Interview).

3.13 International Comparisons: Streamlining PHC Planning, Budgeting and Reporting

Efficient delivery of primary health care (PHC) services requires streamlined processes for planning, budgeting, and reporting - particularly at the facility level. Countries across regions have pursued reforms to reduce the administrative burden on front-line providers and consolidate multiple funding streams into unified management systems. This section situates Tanzania's reform trajectory in comparative perspective and identifies actionable insights.

3.13.1 Progress and Remaining Gaps in Tanzania

Tanzania's efforts through DHFF, supported by the PlanRep and FFARS systems, have significantly increased fiscal autonomy at PHC facility level and improved transparency. Key achievements include:

- **Facility-level autonomy through DHFF**, which disburses multiple revenue streams (HBF, iCHF, NHIF, user fees) directly to facility bank accounts.
- **Digitized planning and accounting** via PlanRep and FFARS, designed to be interoperable through a shared chart of accounts and cost centre codes (Ruhago et al 2023).
- **Community governance activation** through HFGCs, empowered to participate in local health planning and oversight.

However, challenges remain in fully operationalizing these tools due to digital infrastructure gaps, inconsistent system usage across councils, and burdensome manual workarounds despite formal interoperability (Mwakatumbula, 2021).

Furthermore, while Tanzania no longer implements a standalone government RBF scheme, it operates the Programme-for-Results (PforR), supported by the World Bank, which incorporates results-linked financing through core health system structures and the HBF (World Bank, 2022).

3.13.2 Comparative Insights from Uganda, Vanuatu, and Other Countries

Uganda and **Vanuatu** provide particularly illustrative models for streamlining PHC planning and financing:

- **Uganda**: Introduced a Health Sub-Programme under its Programme-Based Budgeting System (PBS), consolidating donor and domestic funds into a unified system that minimizes duplication and integrates results-based financing into core tools (Ministry of Health Uganda, 2023).
- **Vanuatu**: Applies a single-sector Medium-Term Expenditure Framework (MTEF), aligning both government and development partner funds under one annual planning and reporting process (Government of Vanuatu, 2018).

Table 6: Comparison of Country Approaches to PHC Funding Consolidation

Feature	Uganda	Vanuatu	Tanzania
Financing architecture	Multiple PHC funding streams consolidated under a single Health Sub Programme with unified PBS guidance	Development and donor funds aligned to sector plans via MTEF under unified guidelines	DHFF channels multiple sources (HBF, CHF/iCHF, NHIF, user fees) into facility-level accounts; PlanRep and FFARS share chart-of-accounts
Facility-level workplan & budget tools	Integrated PBS module covers public and PNFP providers	MTEF tools reduce parallel systems	PlanRep supports local planning; functionality gaps persist
Reporting burden	One tool covers financial and service data	Donor and government reporting frameworks aligned	Manual workarounds persist despite theoretical PlanRep-FFARS interoperability
Performance-linked financing	RBF embedded in PBS	Performance indicators in sector budgeting	PforR used, but fragmented implementation across systems

Additional global cases include:

- **Ghana**: Budget Management Centres (BMCs) at all health system levels manage unified programmatic budgets, including donor contributions (Osei et al, 2021).
- **Rwanda**: Strategic purchasing links PBF with national IFMIS and DHIS2 systems, eliminating parallel reporting (Ministry of Health Rwanda, 2020).
- **Kenya**: Primary Health Care Networks pool NHIF reimbursements, user fees, and public funds into unified facility accounts overseen at county level (Karimi et al, 2025; Management Sciences for Health, 2023)

Table 7: Broader International Experience on PHC System Consolidation

Country	Approach	Key Achievements
Ghana	Programme-based budgeting with Budget Management Centres (BMCs).	Unified budgets per facility, streamlined execution
Rwanda	PBF embedded into IFMIS and DHIS2	Eliminated donor parallel reporting; verified output-based funding
Kenya	PHC networks with consolidated county-level accounts	Integrated revenue streams with digital monitoring
Uganda	PBS under Health Sub-Programme	Unified PHC grants with single tools
Vanuatu	Sector budgeting via MTEF	No parallel tools; unified annual health planning

These cases underscore how integrated digital platforms, legal frameworks, and joint financing instruments can ease administrative burdens, enhance transparency, and strengthen performance alignment.

3.13.3 Lessons for Tanzania

Tanzania has taken commendable first steps, but comparative experience suggests opportunities to deepen integration:

Table 8: Comparative Table: Tanzania and Peer Country Lessons

Dimension	Tanzania	Lesson from Peers
Digital Tools	PlanRep-FFARS interoperable in design but inconsistently functional	Uganda's PBS is a single tool; Rwanda links payments to DHIS2 data
Consolidated Budgets	DHFF centralizes funds but budget ceilings and siloed planning remain	Ghana's BMCs unify all revenue streams with output-tied budgets
Performance-Based Financing	Implemented through PforR but not embedded in PlanRep	Uganda embeds performance in PBS; Rwanda links payments to DHIS
Donor Coordination	Parallel reporting persists	Vanuatu and Rwanda integrate donor reporting
Governance Support	HFGCs active with uneven capacity	Kenya mandates community participation in planning

3.13.4 Integrating Health Insurance with PHC Financing

Health insurance contributions - via NHIF and future UHI - represent a growing share of PHC funding in Tanzania. However, insurance reimbursements still follow vertical claims pathways, with limited integration into DHFF, PlanRep or FFARS (URT, 2021g)

Peer countries provide valuable examples for the integration of health insurance streams:

- **Rwanda** aligns PBF and insurance reimbursements through shared indicators in DHIS2 and IFMIS (SPARC, 2021).
- **Nigeria** has piloted unified basket fund mechanisms consolidating government, donor, and insurance revenue at the facility level (World Bank Nigeria, 2022).
- **Kenya** requires local governments to integrate NHIF flows into budgeting and community oversight structures (Karimi *et al*., 2025).

3.14 Findings against OECD-DAC Evaluation Criteria

This section synthesizes the Mid-Term Review's empirical findings according to the six OECD-DAC evaluation criteria: relevance, coherence, effectiveness, efficiency, impact, and sustainability. Each criterion is assessed based on triangulated evidence presented in Chapter 3, including budget data, performance indicators, stakeholder interviews, and document analysis.

3.14.1 Relevance

The Health Basket Fund remains highly relevant to Tanzania's national health priorities, particularly the goals outlined in the HSSP V and the Primary Health Care roadmap. As shown in Sections 3.1, 3.2, and 3.3, the HBF has enabled a decentralized financing model that supports essential service delivery at the facility level and aligns with the policy goal of "leaving no one behind." It also contributes to Tanzania's Universal Health Coverage agenda by financing services for populations not covered by insurance. Key informants affirmed that HBF complements both national policy direction and emerging financing reforms, such as UHI.

3.14.2 Coherence

The HBF demonstrates internal coherence by harmonizing funding from multiple DPs through a pooled mechanism using national systems (see Section 3.1). However, Section 3.5 and 3.8 highlight that fragmentation persists between the HBF, PforR, NHIF reimbursements, and vertical donor programs. This undermines administrative efficiency and creates parallel reporting lines. The lack of interoperability across digital systems (PlanRep, FFARS, GoTHOMIS, openIMIS) further complicates financial coherence at the facility level.

3.14.3 Effectiveness

HBF financing has enabled significant service delivery outputs, particularly in PHC facilities, and supported the availability of medicines, outreach services, and essential health commodities (see Sections 3.4, 3.5, and 3.10). However, disbursement delays and rigid expenditure ceilings (see Section 3.4) weaken responsiveness at facility level. Results-based allocation has incentivized performance, but the indicators used (e.g., C-section rates) are sometimes misaligned with the service mandate of lower-level facilities (see Section 3.9).

3.14.4 Efficiency

While the HBF ensures predictable and formula-based allocations (Section 3.3), its full efficiency is compromised by procedural bottlenecks (IAG dependency), multiple and duplicative reporting burdens (Section 3.8), and limited flexibility in reallocating funds to emerging priorities. Facility in-charges often manage financial reporting, procurement, and patient care without administrative support, limiting operational efficiency and data quality.

3.14.5 Impact

The HBF has had measurable positive impact on expanding health access in rural areas, strengthening planning at local level, and institutionalizing community governance mechanisms (see Sections 3.6 and 3.10). Increased autonomy for facilities under DHFF has fostered a sense of ownership, while the HFGCs have enhanced citizen engagement. However, uneven functionality of HFGCs and disparities in fund allocation to underserved areas limit the HBF's equity-enhancing potential.

3.14.6 Sustainability

The upcoming rollout of UHI marks a major shift in Tanzania's health financing architecture. As discussed in Section 3.7, the long-term sustainability of HBF depends on its ability to transition into a complementary financing mechanism for PHC services not covered by insurance. Current funding levels are heavily donor-dependent, and future fiscal space for PHC remains uncertain. A transitional roadmap for aligning HBF with UHI is essential to avoid weakening public goods financing during the shift.

4. KEY FINDINGS AND STRATEGIC ISSUES

Building on the detailed empirical findings presented in Chapter 3, this chapter synthesizes the key strategic issues that affect the functionality, equity, and sustainability of the HBF within Tanzania's evolving health financing landscape. It is structured to support policy decision-making and reform prioritization. Each section presents a major challenge identified through the review, examines its underlying drivers, proposes actionable solutions, and reflects on potential strategic tensions. This synthesis draws from quantitative trends, document review findings, and extensive qualitative insights gathered during the Mid-Term Review.

4.1 Effectiveness of Fund Disbursement Mechanisms

The efficiency and predictability of fund disbursement processes are central to the effectiveness of the HBF. This section synthesizes the key structural and operational bottlenecks identified in the MTR, highlighting both systemic dependencies and emerging opportunities for reform.

Key Challenge

Disbursement delays are a recurring issue, impeding timely implementation of health plans and creating uncertainty at the LGA and health facility levels.

Underlying Issues

The primary bottleneck relates to the procedural dependency on the IAG performance report. In the current arrangement, HBF disbursements cannot be made until the IAG has completed and submitted its annual report and until side agreements are signed between the Government and Development Partners. These dependencies cause systemic lags in the release of funds.

> "*Every year we are late with starting activities because we wait for the IAG report and side agreements to be signed*." (CHMT Member, Field Interview).

This misalignment between the start of the fiscal year and the actual flow of funds disrupts service delivery cycles, undermines the credibility of planning processes, and reduces absorption rates at the district and facility levels.

Additionally, multi-step approval processes within the Ministry of Finance (MoF) and the involvement of several layers of oversight (MoH, PO-RALG, and DPs) contribute to the cumulative delay.

> "*You can have the plan and budget ready, but without the IAG signal and the signed side agreement, nothing moves*." (Regional Accountant, Northern Zone, Field Interview).

Field interviews also noted that after Development Partners disburse funds to the Government holding account, there can be additional internal delays before the funds reach sub-national levels. These delays may relate to broader cash flow management practices and prioritization decisions within the national treasury system. While not always formally documented, such lags reduce predictability for local implementers.

Further, variations in financial years among partners contribute to delays in disbursement. While some partners begin their financial year in January and others in April, the Government of Tanzania's financial year starts in July. These differences significantly affect the timely release of funds to the holding account and subsequent transfer to the LGAs.

Proposed Solutions and Strategic Considerations

To improve timeliness, the following strategies are proposed:

- Decouple the IAG reporting cycle from disbursement triggers, particularly for Development Partners not applying performance-based disbursement logic.
- Introduce conditional or phased disbursements allowing for partial fund release while awaiting full audit clearance.
- Establish clearer timelines and roles for each actor in the disbursement chain, building accountability into the process.
- Develop and implement a digital fund flow monitoring tool to track disbursement progress across all administrative levels. The tool should integrate with PlanRep and FFARS where feasible, provide real-time visibility on delays, and be accessible to stakeholders at national and sub-national levels.

These proposals were widely supported during field consultations:

> "*If the IAG Terms of Reference were agreed earlier and the audit cycle streamlined, we wouldn't lose the first quarter every year*." (KII, DP Representative, HBF Committee, Field Interview).

> *"We are blind until someone calls to say funds have arrived. A system showing the disbursement progress would save us time and blame."* (District Health Treasurer, Central Zone, Field Interview).

Strategic Tension Identified

There is an inherent trade-off between safeguarding fiduciary oversight and ensuring operational flexibility. While the IAG mechanism aims to uphold financial accountability, its procedural centrality creates rigidity that hinders program responsiveness. A shift toward more agile risk-

based disbursement mechanisms, particularly for non-performance-based partners, could strike a better balance. In addition, delays not directly linked to the audit cycle - such as internal fund release bottlenecks within the national financial system - underscore the need for increased transparency and real-time tracking of the disbursement chain.

4.2 Equity and Allocation Formula Limitations

The equity orientation of the HBF is one of its central strengths. However, field evidence and financial analysis reveal that the current resource allocation formula does not fully reflect the equity and service needs of low-capacity or underserved areas.

Key Challenge

The allocation formula is increasingly perceived as inequitable, especially at the primary health care level, where structurally disadvantaged facilities and councils face disadvantages in both planning and resourcing.

Underlying Issues

The current allocation formula includes a performance-based component linked to service volume (pregnant mothers attending first ANC visit < 20 years as well as > 20 years; pregnancy mothers at least attended at least 4 visits; and institutional deliveries coverage), and other facility indicators. This benefits better-equipped health centres and hospitals as compared to under resourced facilities in terms of healthcare commodities (medicines, medical supplies, medical equipment), staff cadre deployed at the facility as well as location, often located in urban or better-resourced councils.

> "*We don't do C-sections at our dispensary, but it still affects our performance score. That's not fair*." (Facility In-Charge, Dispensary, Field Interview).

Councils with weaker infrastructure and low baseline performance struggle to meet the criteria for higher allocations. This creates a cycle where historically underperforming LGAs receive less funding, limiting their ability to improve.

The removal of the flat-rate base grant for facilities - previously part of the formula - has further penalized dispensaries and facilities with lower patient volumes or limited capacity to document performance data.

> *"Before, at least we knew a basic amount was coming. Now, performance indicators we can't influence make us lose funds*." (CHMT Member, Western Zone, Field Interview).

Although the current formula includes components for population, morbidity, poverty, and transport difficulty, the weight given to performance indicators can overshadow these factors.

Proposed Solutions and Strategic Considerations

- Reintroduce a guaranteed base allocation to all facilities, ensuring minimal operational funding regardless of performance levels.
- Establish a dedicated equity window for low-performing and hard-to-reach health facilities and LGAs to address structural gaps.
- Rebalance the formula to reduce the weight of performance-based indicators that are not applicable across all facility types.

- Revise performance metrics to better reflect service realities at the dispensary level (e.g., outreach coverage, ANC visits, or immunization rates).

"*Equity should be about needs, not just performance. You can't penalize a rural dispensary for not having a theatre."* (KII, DP representative, HBF Committee, Field Interview).

Strategic Tension Identified

The core tension lies in reconciling performance incentives with equity principles. A rigid results-based model can undermine redistributive goals when applied uniformly across vastly different contexts. Achieving equity requires recognizing and compensating for structural disadvantage — not just rewarding high service outputs.

4.3 PHC Financing Adequacy and Sustainability

Primary Health Care is the cornerstone of Tanzania's health system and the primary focus of the HBF. While the HBF has provided predictable and pooled resources for PHC for over two decades, the adequacy and long-term sustainability of PHC financing remain critical concerns, particularly in the context of transitioning toward UHI.

Key Challenge

The HBF alone cannot guarantee adequate financing for PHC in the medium-to-long term. Government allocations remain below required levels, and there is uncertainty about future development partner contributions. At the same time, the transition to UHI raises concerns about whether preventive and promotive services - traditionally funded through HBF - will be sufficiently covered through insurance mechanisms. This concern reflects current uncertainties in UHI policy design rather than an inherent restriction in insurance financing. With the right regulatory framework, UHI reimbursements can be applied flexibly across all service categories in a facility's approved plan.

Underlying Issues

Government funding for the health sector has grown slowly in recent years and remains heavily reliant on donor support, especially for PHC-level non-salary recurrent expenditures. Analysis of FFARS data showed that some LGAs experienced real-terms reductions in funds received over the review period, affecting their capacity to maintain service delivery.

> "*Medicines are being covered more by the government now, but for outreach, fuel, or supervision we still rely on the HBF*." (CHMT Accountant, Lake Zone, Field Interview).

The move toward UHI introduces opportunities to enhance financial protection and expand funding. However, it is not yet clear how UHI revenues will be allocated and whether they will prioritize PHC or focus on curative services at higher levels of care. This curative bias is common internationally, but it is not inevitable. While UHI reimbursement structures in many countries tend to focus on funding curative services, there is no inherent requirement that funds be restricted to such uses. While UHI reimbursement structures in many countries tend to focus on funding curative services, there is no inherent requirement that funds be restricted to such uses. In Tanzania, UHI revenues - alongside HBF and other public allocations - should be planned and budgeted within a single, comprehensive facility activity plan that covers preventive, promotive, curative, and administrative needs.

This integrated planning approach allows facilities to deploy resources flexibly toward their highest-priority service gaps, including investments in infrastructure, staff incentives, and outreach, without being constrained by the original source of funds. The main challenge is

therefore not only the adequacy of total PHC funding, but also the removal of rigidities in current rules and processes that limit the integrated use of available revenues. These restrictions stem partly from existing expenditure rules that require activities to be linked to a specific source, each with its own thresholds and earmarks. Harmonizing these rules - as discussed in 3.9.6 - would allow facilities to truly operate under a single comprehensive plan and budget, unlocking the full potential of both HBF and UHI.

To make this integration work in practice, facilities and councils will also need visibility on how UHI resources are flowing. Simple, LGA-accessible monitoring tools that track UHI membership uptake and reimbursement flows - linked to FFARS and PlanRep data - would enable planners to identify coverage gaps early and coordinate HBF and UHI resources to protect service continuity.

Moreover, UHI may not replace the need for public investment in public goods such as disease prevention, health promotion, and community health.

> "*Insurance is good, but who will pay for the poor? And who covers outreach? Insurance pays for the patient, not the population*." (KII, Health Economist, National Interview, Field Interview).

There is also concern about coverage for currently exempt groups under UHI, including children, pregnant women, and the elderly, who are major users of PHC services. Without clear financing provisions, the burden could shift back to local governments or facilities themselves.

Proposed Solutions and Strategic Considerations

- MoH and MoF should define a clear, publicly stated trajectory for gradually increasing the share of domestic funding allocated to PHC-level service delivery.
- Establish safeguards within UHI design to guarantee that essential PHC services - including non-insurable and public health functions - remain publicly financed.
- Introduce a blended financing approach, where UHI reimbursements supplement, but do not replace, HBF and government block grants for PHC.
- Review and harmonize expenditure rules so that facility plans and budgets - developed through FFARS and PlanRep - can fully integrate HBF, UHI, and other funds into a single flexible financing framework, allowing managers to allocate resources across preventive, promotive, curative, and administrative needs without unnecessary restrictions.
- Encourage DP alignment around PHC as a strategic investment priority during and after the UHI transition.

"*The future of PHC must be multi-financed. UHI, yes, but also government and donors. It's not either - or*." (KII, DP representative, HBF Committee, Field Interview).

Strategic Tension Identified

There is a potential misalignment between insurance-driven financing models and the broader functions of PHC. Insurance tends to focus on individual-level, curative services, while PHC encompasses population health, outreach, and community engagement. Ensuring sustainability means balancing insurance expansion with sustained public investment in PHC as a public good.

4.4 Flexibility and Responsiveness of Facility Funding

The capacity of health facilities to adapt funding to local needs is critical for delivering responsive, high-quality care. While DHFF under the HBF has substantially improved autonomy at the facility level, current rules and planning practices still constrain flexibility in several important ways.

Key Challenge

Facilities face constraints in adapting resources to actual service delivery needs due to rigid expenditure ceilings, inconsistent alignment between systems, and limited reallocation mechanisms. These constraints limit local responsiveness and undercut the intended benefits of decentralization under DHFF.

Underlying Issues

The current guidelines prescribe fixed expenditure ratios, such as the requirement that 35% of HBF funds be spent on medicines and medical supplies. However, with increased provision of medicines through MSD and the Jazia Prime Vendor System, many facilities report an oversupply in some items and underfunding for other essential categories such as supervision, fuel, and outreach. The oversupply may be attributed not only to some facilities' inability to accurately predict their needs, resulting in an overestimation of required quantities, but also to their failure to closely monitor medication consumption, complicating future order adjustments.

> "*We get medicines from MSD now - even if they're enough, we must still spend 35% on drugs. It would help to redirect that to transport or outreach*." (Facility In-Charge, Southern Highlands, Field Interview).

Another issue is that reallocation flexibility is limited, especially at lower-level facilities. The budgeting process via PlanRep locks facilities into predefined categories, and manual reconciliation with FFARS means that adjustments mid-year are often impractical without district or regional approval.

> "*Our budget is fixed in PlanRep. If needs change, we can't adjust easily unless we go through the council - and it takes time*." (CHMT Member, Central Zone, Field Interview).

Furthermore, the lack of integration between budgeting and reporting systems exacerbates rigidity. Discrepancies between PlanRep and FFARS data require manual alignment, often delaying procurement and financial decisions.

Proposed Solutions and Strategic Considerations

- Revise expenditure ceilings to allow conditional flexibility, particularly when in-kind government provision of specific inputs (e.g. medicines) exceeds local requirements.
- Establish a simplified reallocation mechanism at the facility level, empowering in-charges to adapt to emergent service needs with minimal bureaucratic delay.
- Enhance interoperability between PlanRep and FFARS to reflect real-time adjustments in budget lines and improve transparency.
- Train facility and CHMT staff in adaptive budgeting principles to ensure that increased flexibility does not compromise accountability.

"If we are trusted to manage funds, we should also be trusted to respond to what our patients need - not just follow the old spending rules." (Health Centre Nurse, Lake Zone, Field Interview).

Strategic Tension Identified

There is an inherent tension between rules-based financial discipline and the flexibility needed to respond to dynamic service delivery needs. While fixed ratios promote standardization and auditability, they risk misalignment with actual demand patterns, especially at the PHC level. Future reforms must strike a balance between flexibility and fiduciary accountability to support responsive facility management. Comparative experience from countries such as Uganda and Ghana (see 3.13) shows that greater local budget flexibility, paired with strong accountability, can enhance responsiveness - offering relevant lessons for refining Tanzania's DHFF expenditure rules.

4.5 Coherence and Harmonization with Other Funding Sources

The Health Basket Fund operates within a diverse health financing ecosystem in Tanzania, including PforR, vertical programs (e.g., immunization, HIV/AIDS), and health insurance reimbursements (NHIF, iCHF, and emerging UHI mechanisms). While the HBF is designed to work through government systems and complement other funding sources, fragmentation in planning, budgeting, and reporting persists.

Key Challenge

The lack of full coherence and harmonization across health financing modalities increases transaction costs, weakens data alignment, and places significant administrative burdens on facilities and councils. This reduces the overall efficiency and effectiveness of financing at the PHC level.

Underlying Issues

Although development partners contributing to the HBF have made efforts to align reporting requirements with government systems, parallel systems remain prevalent, particularly in vertical programs and insurance claims processes. For example, health facilities often need to enter the same data into multiple systems, including FFARS, PlanRep, GoTHOMIS, NHIF/iCHF platforms, and paper-based PforR tools.

> "*We use FFARS, PlanRep, GoTHOMIS, and PforR paper forms - and still they ask for printed reports. It's exhausting*." (Dispensary In-Charge, Southern Zone, Field Interview).

This duplication not only wastes time but also increases the risk of data inconsistencies. For instance, inconsistencies between service data in DHIS2 and financial data in FFARS complicate supervision and performance monitoring.

Efforts to harmonize systems through the Muungano Gateway and ongoing digital health reforms offer promise, but full interoperability has yet to be realized.

> "*You have DHIS2 for service data, FFARS for spending, and then NHIF is separate. The same client visit can appear three times*." (District Health Secretary, Lake Zone, Field Interview).

There is also limited clarity on how insurance reimbursements under the new Universal Health Insurance scheme will be integrated with HBF-supported services. Without alignment, insurance funding risks duplicating or replacing essential HBF support for PHC. Ensuring that UHI reimbursements are programmed within integrated facility plans and budgets - rather than as parallel curative-focused streams - will be essential to maintain balanced investment across preventive, promotive, and curative services.

Field interviews confirmed that perceived fragmentation goes beyond systems and into day-to-day implementation. Facility managers and CHMT staff reported overlapping guidelines, shifting

priorities, and frequent training cycles on unaligned tools. These inconsistencies dilute harmonization gains and contribute to planning fatigue and reporting inefficiencies.

> *"They train us on one system, then the next quarter, there's a different guideline. It's hard to keep up." (*CHMT member, Western Zone, Field Interview).

Beyond digital and procedural fragmentation, several Development Partners expressed concern that sub-national health financing is becoming increasingly siloed. Councils are now managing a growing number of vertical or project-based funding streams - such as those for immunization, nutrition, and disease-specific programs - with separate planning and reporting formats. This trend risks diluting the original purpose of the HBF as a harmonizing platform for PHC financing. Development Partners advocated for a renewed commitment to Sector-Wide Approach (SWAp) principles and emphasized the need to bring major global health initiatives into closer alignment with the HBF structure.

> *"Without harmonization, we are back to the pre-basket days—just better digitized."* (KII Development Partners, Field Interview).

> *"We need to bring global health initiatives into the HBF tent."* (KII Development Partners, Field Interview).

Proposed Solutions and Strategic Considerations

- Accelerate technical and institutional efforts to ensure interoperability among government health information systems, including FFARS, PlanRep, GoTHOMIS, and NHIF/ CHF-IMIS.
- Develop unified reporting standards that consolidate requirements across donors, government entities, and insurance providers.
- Clearly define roles of HBF and UHI in PHC financing to avoid duplication and ensure complementary use of funds, particularly during the UHI transition phase.
- Promote the use of integrated dashboards for supervisors and planners at CHMT and regional levels to consolidate financial, performance, and claims data.

Harmonization should aim not only at reporting and planning templates, but also at the underlying expenditure rules, so that all sources can fund the same integrated facility plan without artificial limits based on the origin of funds. As part of this harmonization, the development of LGA-accessible monitoring tools for UHI membership uptake and reimbursement flows would ensure that insurance resources are tracked alongside HBF and other public funds, allowing planners to coordinate allocations and protect service continuity during the UHI transition.

> *"It's not just about merging systems — it's about agreeing on one set of data and one process."* (Development Partner Representative, HBF Committee, Field Interview).

Strategic Tension Identified

The core tension lies between centralized accountability needs (from donors and vertical programs) and decentralized service delivery realities. While harmonization offers efficiency gains and improved oversight, entrenched systems, donor requirements, and sectoral silos slow integration. There is a pressing need for stronger financing and accountability systems and clear frameworks to align external and domestic financing streams toward unified PHC support. The integration models of Vanuatu and Rwanda (see 3.13) underscore that unified planning and reporting frameworks are achievable, and could guide Tanzania's efforts to harmonize HBF, UHI, and vertical program flows.

4.6 Accountability, Results, and M&E Frameworks

The Health Basket Fund has adopted a performance-oriented approach to enhance accountability and improve service delivery outcomes. Since the 2016–2020 cycle, the HBF moved from purely input-based budgeting to partial programme for results, introducing performance scorecards and output-linked indicators at facility, council, and regional levels. These reforms are anchored in government-led systems and reporting tools but have encountered implementation challenges.

Key Challenge

Monitoring and evaluation (M&E) frameworks introduced under the HBF have increased accountability but are inconsistently applied across councils and facilities. Data quality, indicator relevance, and supervision capacity limit the utility of performance-based allocation mechanisms.

Underlying Issues

Performance monitoring under the HBF is guided by the HBF Scorecard, which integrates selected service delivery indicators such as skilled birth attendance, caesarean section rates, and outpatient utilization. While this has introduced greater rigor into budgeting and accountability, many indicators are poorly suited for all PHC levels.

> "*We don't perform C-sections, but our funding depends on it. The scorecard doesn't reflect our work."* (Dispensary In-Charge, Field Interview).

Supervision visits by CHMTs - a critical part of the performance framework - remain underfunded and irregular. This limits the ability of local managers to validate reports, provide feedback, and support corrective action.

However, the nature and quality of CHMT supervision varied considerably across regions. In some councils, it was described more as a fault-finding or punitive exercise rather than a supportive engagement. This perception undermines the intended learning function of supervision and contributes to demotivation at the facility level.

> *"They come to inspect, not to help. It's demoralizing."* (Dispensary In-Charge, Southern Zone, Field Interview).

Moreover, the integration of financial data (FFARS) and service data (DHIS2, GoTHOMIS) into a single M&E system remains incomplete. Health workers frequently report mismatches between reported service volumes and financial allocations, creating confusion and distrust.

> "*We get flagged for inconsistencies between DHIS2 and FFARS, but they're different systems - how can we fix that?"* (CHMT Member, Central Zone, Field Interview).

Additional field interviews with CHMT and RHMT members further highlighted structural accountability challenges at the sub-national level. Many RHMTs described having formal oversight responsibilities but limited authority or resources to enforce standards or support underperforming councils. Likewise, CHMTs reported that they are often pulled into micro-managing budget details at facility level due to capacity gaps, rather than functioning in a strategic or supervisory role.

> *"We are expected to oversee without authority. If a facility underperforms, we have no leverage."* (RHMT Member, Southern Highlands Zone, Field Interview).

Despite the emphasis on results-based allocations, CHMTs and RHMTs noted weak alignment between performance data and resource decisions. Facility scorecards are often submitted but not analyzed; poor performers are neither penalized nor supported differently. There is a call to establish clearer M&E accountability loops, including at RHMT level.

"A poor score means nothing unless someone acts on it." (RHMT Officer, Western Zone, Field Interview)

"Data informs the reports, not the decisions." (CHMT Representative, Coastal Zone, Field Interview).

These findings suggest a misalignment between accountability expectations and operational capacity at the middle tiers of the health system. Without a stronger feedback loop between RHMTs, CHMTs, and facilities, performance-based mechanisms risk becoming overly centralized, with limited space for local adaptation or support-based improvement.

PforR schemes - operating alongside the HBF - have their own parallel monitoring protocols, often requiring duplicate paperwork and validation steps. This leads to administrative overload at the facility level.

"*PforR comes to check things in their own way. It's separate from what the HBF looks for."* (Health Centre Manager, Southern Highlands, Field Interview).

Proposed Solutions and Strategic Considerations

- Revise the HBF Scorecard to include more context-sensitive indicators for lower-level PHC facilities, such as outreach services, health education activities, or community health worker integration. Specific indicators, such as caesarean section rates, should only be applied to facilities that have the capacity to perform such procedures, as outlined in the service delivery guidelines.
- Increase budgeted support for routine supportive supervision, including transportation allowances and follow-up mechanisms.
- Develop integrated dashboards for CHMTs and regional teams to view service, financial, and PforR indicators in one interface.
- Harmonize M&E protocols across the HBF and PforR programs to reduce parallel reporting and increase data reliability.
- Expand training for facility in-charges and CHMTs on data interpretation, validation, and performance-linked budgeting.

"Data is collected everywhere — but without analysis or use, it's just a burden. We need to shift toward using it to solve problems." (National Senior Officer, MoH, Field Interview).

Strategic Tension Identified

There is a trade-off between technical rigor in performance measurement and operational feasibility at the facility level. Overly complex or misaligned indicators reduce morale and data quality, while weak supervision erodes accountability. A balanced approach that invests in capacity, aligns indicators with service realities, and emphasizes learning over punitive audits will improve HBF effectiveness and sustainability.

4.7 Community Accountability and Local Governance

The HBF explicitly supports decentralized health governance and aims to foster citizen participation in facility-level decision-making. This objective is operationalized through the DHFF approach and the strengthening of HFGCs. While considerable progress has been made in formalizing governance structures, meaningful community oversight remains variable.

Key Challenge

Despite structural reforms, HFGCs often lack the capacity, confidence, and continuity to fulfill their oversight and accountability roles effectively. Citizen engagement in planning and budgeting is inconsistently applied and remains largely symbolic in many cases.

Underlying Issues

HFGCs exist in all facilities and are now formally included in planning and budgetary processes under DHFF. Their members receive allowances funded through HBF, and the frequency of meetings has increased since the introduction of DHFF.

Despite these formal arrangements, many HFGCs lack training on roles and responsibilities. Their ability to understand budget allocations, interpret reports, or monitor expenditures is limited, especially in rural and low-literacy settings.

> "*We are invited to meetings and we can give opinions, but many don't understand the documents well*." (HFGC Member, Western Zone, Field Interview).
>
> "*The committee signs the plans, but it's the in-charge who prepares everything. There is no challenge from them*." (Health Centre In-Charge, Lake Zone, Field Interview).

Additionally, the power dynamics between facility staff and community representatives often discourage open dialogue. In some cases, committee members expressed reluctance to question technical decisions, citing their subordinate social status or lack of technical knowledge.

There are also inconsistencies in how HFGCs are supported and supervised by CHMTs and regional health management teams. The absence of a harmonized training curriculum or structured follow-up weakens the long-term functionality of these bodies.

Proposed Solutions and Strategic Considerations

- Finalise and rollout the newly developed national HFGC training modules to standardize understanding of roles, budgeting processes, and oversight responsibilities.
- Introduce simple reporting formats tailored for non-technical users, enabling meaningful participation without requiring advanced accounting knowledge.
- Institutionalize community scorecards or public display of key indicators (e.g., medicine availability, funds received) at facility level.
- Encourage CHMTs to provide feedback and follow-up on HFGC resolutions, creating a feedback loop that validates their input.
- Promote gender and youth inclusion within HFGCs to reflect broader community perspectives.

> "*We should not only be asked to attend meetings but also given tools to monitor how money is spent*." (HFGC Chairperson, Northern Zone, Field Interview).

Strategic Tension Identified

A core tension exists between the formal recognition of community accountability and the substantive empowerment of HFGCs to exercise it. Without targeted capacity building, simplified tools, and responsive supervision, community participation risks becoming a procedural formality rather than a vehicle for improved transparency and local ownership.

5. CONCLUSIONS AND STRATEGIC RECOMMENDATIONS

This chapter synthesizes the major conclusions from the Mid-Term Review of the Health Basket Fund and outlines strategic recommendations to enhance its performance and sustainability. The findings confirm that while the HBF remains a foundational element of Tanzania's health financing architecture, a number of systemic and operational adjustments are necessary for it to meet evolving policy goals, especially in the context of Primary Health Care and Universal Health Coverage.

5.1 Key Conclusions

The MTR identified strong alignment between the HBF and national health sector priorities, with the Fund continuing to play a critical role in enabling PHC service delivery. However, its effectiveness and efficiency are constrained by delayed disbursements, rigid expenditure rules, parallel reporting systems, and allocation formulas that may disadvantage underserved areas. The transition to UHI represents a historic opportunity, but also a strategic inflection point requiring careful alignment of roles, financing flows, and policy intent.

Key findings from the MTR include:

- **The HBF remains central to PHC financing and equity**, particularly in rural and underserved areas. However, disbursement delays and procedural bottlenecks reduce responsiveness and disrupt planning cycles at facility and council levels.
- **The current allocation formula and performance indicators generate equity concerns**, disproportionately benefiting better-resourced LGAs and penalizing low-capacity or remote facilities.
- **Health facilities face a high administrative burden**, stemming from fragmented reporting systems and lack of dedicated support staff. This diverts attention from service delivery and affects the quality and timeliness of financial reporting.
- **Monitoring and accountability of fund flows remain weak due to the lack of an electronic tracking system.** At present, disbursement monitoring relies on a manual process ("fund floor") outlined in the Memorandum of Understanding. Developing and implementing an electronic monitoring tool would enhance transparency, enable timely detection of delays, and support more effective follow-up.
- **The rollout of UHI marks a major shift in Tanzania's health financing architecture and presents both opportunities and risks.** While UHI will expand financial protection through service-based reimbursements, mainly for curative care, the HBF remains critical to ensure equitable financing for disadvantaged facilities through needs-based allocation. HBF can support services not covered by insurance and improve equity by directing resources to underserved areas. A clear transition roadmap is needed to align HBF with UHI while sustaining support for public goods and equity-sensitive PHC financing.
- **The ongoing transition to UHI is reshaping Tanzania's health financing landscape.** The HBF must adapt to complement insurance schemes by securing public financing for essential PHC services, particularly those not easily covered by insurance.
- **Community participation and accountability mechanisms have improved,** especially through Health Facility Governing Committees. However, their effectiveness

varies considerably across regions and facilities. HFGCs require additional training and appropriate tools, including access to simplified financial data, budgeting templates, and performance dashboards, showing a comprehensive picture for their health facility across funding sources, to effectively engage in financial planning, monitor expenditures, and hold health facility staff accountable.

5.2 Strategic Recommendations

Based on the evidence and findings presented, the following recommendations are proposed to the Ministry of Health, PO-RALG, and Development Partners supporting the HBF. Where relevant, these recommendations draw on international lessons (see 3.13) that demonstrate how consolidated financing architectures and streamlined reporting can reduce administrative burdens and improve resource use.

5.2.1 Streamline Fund Flow and Disbursement Mechanisms

- **Finalize the Internal Auditor General's Terms of Reference by December each year** to enable timely audit initiation and avoid delays at the start of the fiscal year.
- **Redefine the role of the IAG report** from a strict precondition for disbursement to a compliance tool allowing staggered releases. Initial tranches should be based on approved plans and budgets, with subsequent releases contingent on audit verification or other agreed accountability checks. This approach could also be adapted by performance-based partners such as the World Bank.
- **Develop and institutionalize a digital fund flow monitoring tool** to track the entire disbursement process from MoF through MoH, PO-RALG, LGAs, and down to facilities. The tool should provide real-time visibility to all stakeholders, flag delays for follow-up, integrate with PlanRep and FFARS where feasible, and feed directly into JHSR and quarterly review dashboards. This will replace the current manual "fund floor" process, enhancing timeliness, transparency, and accountability.

  "If we had a dashboard showing where the money is stuck, we could act faster. Now we wait and hope." (RHMT member, Lake Zone, Field Interview).

  This reflects strong sub-national demand for real-time tracking to improve responsiveness and reduce bottlenecks.

5.2.2 Strengthen Equity in Allocation

- **Reintroduce a guaranteed base allocation** to ensure all health facilities have sufficient resources to meet minimum operational requirements.
- **Create a targeted equity adjustment mechanism** to provide additional funding to underperforming, high-need, or underserved LGAs, with priority for rural and hard-to-reach areas.
- **Link the equity adjustment** mechanism to existing community accountability structures (e.g., HFGCs, ward development committees) to ensure funds address locally identified service gaps without creating parallel processes.
- **Revise performance indicators** to reflect facility capacity and context, avoiding metrics that penalize facilities for services beyond their control or mandate. Use these adjusted indicators together with the equity adjustment mechanism to ensure allocations address service gaps in disadvantaged LGAs and facility types.

5.2.3 Increase Spending Flexibility at Facility Level

- **Revise rigid expenditure ceilings** (e.g., the 35% requirement for medicines) to reflect multiple sources for funding medical supplies and current commodity availability through MSD and Jazia PVS.
- **Permit reallocation of unspent or over-budgeted funds** within approved cost centres, using clear criteria and transparent reporting to maintain accountability.
- **Create a dedicated funding line within HBF for retention and hardship incentives in underserved LGAs**, linked to transparent allocation rules and aligned with national HRH policy.

5.2.4 Simplify Financial and Performance Reporting

- **Harmonize planning and reporting templates** across key funding streams (e.g., HBF, PforR, insurance reimbursements) to reduce duplication.
- **Accelerate implementation of the national interoperability framework**, linking FFARS, PlanRep, GoTHOMIS, eLMIS, and insurance claims systems (NHIF, openIMIS for iCHF, to be determined for UHI) through the Muungano Gateway and Health Information Mediator.
- **Deploy administrative support personnel or shared financial service units** to support clinical staff at PHC facilities with routine reporting and data entry tasks.
- **Implement a coordinated national training strategy** on integrated planning, budgeting, and reporting tools, ensuring consistent and accurate use across facilities and councils.

5.2.5 Align HBF with UHI Reforms and Long-Term Financing Strategy

- Ensure **continued public financing of preventive and promotive services** not covered by insurance.
- Develop a **transitional roadmap for integrating facility financing streams** with UHI while preserving earmarked equity-sensitive PHC funding.
- **Strengthen national and sub-national capacity for strategic health purchasing** to manage blended financing environments, including planning, contracting, monitoring, and evaluation.
- **Establish a multi-year joint expenditure and financing forecast for PHC** aligning HBF and UHI contributions to ensure predictability and sustainability of essential services funding. As part of this process, review and harmonize expenditure rules and source-specific restrictions so that facility plans and budgets (developed through FFARS and PlanRep) can fully integrate HBF, UHI, and other funds into a single, flexible financing framework. This would allow managers to allocate resources according to comprehensive service priorities - covering promotive, preventive, curative, and administrative needs - while maintaining accountability.
- **Embed the recommended HBF fund flow monitoring tool** in this roadmap as a practical transparency and accountability mechanism during the UHI transition.
- **Develop and deploy complementary monitoring tools for UHI implementation** - tracking enrolment trends, service utilization patterns, and financial flows - and make these available at LGA level. This will enable councils to monitor UHI uptake, assess equity in coverage, and coordinate UHI and HBF resource use more effectively.

5.2.6 Enhance Accountability and Local Ownership

- **Strengthen the role of HFGCs, village councils, and ward development committees** in identifying local priorities, guiding resource use, and monitoring results - especially for equity-adjusted or conditional funding.
- **Scale up training and operational support for HFGCs** to improve financial literacy, planning input, and oversight capacity.
- **Institutionalize digital performance dashboards** accessible at council and regional levels to support monitoring, peer learning, and feedback loops.
- **Provide structured access to the fund flow monitoring dashboard** for facility-level and council stakeholders across major funding sources to improve planning accuracy and reduce uncertainty. Such monitoring tools will also be an important prerequisite for the roll-out of UHI.

5.2.7 Clarify and strengthen the institutional accountability roles of CHMTs and RHMTs within the DHFF and HBF architecture

- **Clearly define supervisory mandates, escalation protocols, and performance expectations** for CHMTs and RHMTs.
- **Empowering RHMTs to provide structured support and follow-up** for underperforming councils through formalized review and support processes.
- **Ensure sufficient operational resources** (e.g. transport, supervision allowances, digital tools) for CHMTs and RHMTs to fulfill oversight duties effectively.
- **Expand use of digital supervision dashboards** integrating service indicators, financial data across different funding sources, and community feedback to enable real-time accountability and targeted support.

"We are expected to oversee without authority. If a facility underperforms, we have no leverage." (RHMT Member, Southern Highlands Zone, Field Interview).

5.2.8 Strengthen Strategic Stewardship and Joint Governance

- **Define shared strategic goals and milestones for the HBF,** aligned with broader reforms such as UHI, and embed them in joint planning and review processes including the JHSR.
- **Re-establish strong joint governance mechanisms** to enable coordinated policy dialogue between the Government and Development Partners.
- **Increase visibility of HBF-supported reforms through targeted communication strategies** that highlight contributions to service delivery, equity, and facility autonomy.

  "The HBF became embedded, but invisible. It is part of the system, yet no one owns it strategically anymore." (KII, Senior Health Financing Expert, Field Interview).

Overall synthesis: The recommendations in 5.2 provide a coherent package of operational, equity, flexibility, reporting, and governance reforms that address the key bottlenecks identified in the MTR. When implemented in parallel and with clear leadership from MoH, PO-RALG, and Development Partners, these measures will enhance timeliness, equity, efficiency, and accountability in HBF operations. The next step is to translate these recommendations into a phased implementation plan, as outlined in 5.3, to ensure their sustainable adoption.

5.3 Implementation Considerations

The strategic recommendations outlined in Section 5.2 require phased and coordinated implementation across government ministries, sub-national structures, and partner agencies. Comparative reforms described in 3.13 suggest that phased adoption of unified tools, combined with early capacity investment, can accelerate integration and reduce transaction costs in Tanzania's HBF operations. Success will depend on:

- Strong political will and high-level policy coordination, particularly around integrating UHI roll-out with continued support of the HBF.
- Dedicated technical support and resource investment to improve system interoperability.
- Sustained donor engagement through the HBF mechanism, aligned with national reforms.
- Continued evaluation and adaptive learning to track impact and inform mid-course corrections.

The MTR findings can be structured using the **three-stage framework of innovation adoption** described in Stoermer et al. (2025):

1. Innovation Development
2. Integration into Service Delivery Systems
3. Institutional Adoption at Policy Level

This framework provides a sequenced pathway for action, linking each stage to specific tools and measures recommended in Section 5.2.

5.3.1 Innovation Development

Objective: Design and test targeted tools, mechanisms, and processes that directly address identified HBF bottlenecks.

Key Actions:

- **Develop and pilot a digital fund flow monitoring dashboard** (see 5.2.1) that tracks disbursement progress from DPs to MoF to facilities, if feasible integrates with PlanRep and FFARS, and generates automatic alerts for delays. *Lead actors:* MoH, PO-RALG, MoF, with DP technical support.
- **Design streamlined, interoperable reporting platforms** (linked to 5.2.4) to reduce duplicate data entry and integrate financial, service, and insurance data. *Lead actors:* MoH (Digital Health), PO-RALG ICT teams, NHIF, and DPs.
- **Refine equity allocation parameters and operational guidelines** (see 5.2.2) to reintroduce a guaranteed base allocation for all facilities, create a targeted equity adjustment mechanism for underperforming or underserved LGAs (prioritizing rural and

hard-to-reach areas), and ensure performance metrics are context-sensitive to avoid penalizing low-capacity facilities. *Lead actors:* MoH, PO-RALG.

- **Develop supportive supervision models** (linked to 5.2.7) that prioritize coaching and peer learning over punitive audits, with clear tools and templates for CHMTs and RHMTs. *Lead actors:* RHMTs, CHMTs, MoH.

5.3.2 Integration into Service Delivery Systems

Objective: Align and embed newly developed tools and mechanisms into day-to-day operations at ministerial, regional, council, and facility levels as well as oversight bodies to maximize efficiency, coherence, and sustainability.

Key Actons:

- **Ensure full technical and operational integration of core planning, budgeting, and reporting systems** - including FFARS, PlanRep, GoTHOMIS, eLMIS, NHIF/iCHF, and future UHI - through the Muungano Gateway and Health Information Mediator. This integration should enable these systems and vertical programme platforms to function as a single workflow for financial and service planning, eliminating duplicate entries and improving data consistency (see 5.2.4). *Lead actors:* MoH (Digital Health), PO-RALG (ICT and Planning Divisions), MoF, NHIF, CHMTs, DPs.
- **Embed equity allocations** (base allocations and targeted equity window) into the annual planning cycle with clear disbursement, reporting, and accountability procedures (see 5.2.2). *Lead actors:* MoH, PO-RALG, MoF, CHMTs, HFGCs.
- **Institutionalize reallocation flexibility** at facility level (see 5.2.3) by revising guidelines and training in-charges in adaptive budgeting principles. *Lead actors:* MoH, PO-RALG , CHMTs.
- **Analyze supportive supervision models** for improvements (see 5.2.7) and integrate those into RHMT and CHMT annual workplans, with budget lines for transport, allowances, and follow-up activities. *Lead actors:* RHMTs, CHMTs, MoH, PO-RALG.
- **Roll out the digital fund flow dashboard** nationally (from 5.3.1) with standard operating procedures, defined access rights, and ICT support at all levels. *Lead actors:* MoH, PO-RALG, MoF, regional ICT focal persons.
- **Integrate IAG process improvements** into the operational calendar: finalize IAG Terms of Reference by December each year, and apply the revised role of the IAG report (see 5.2.1) so that it does not block initial disbursements. *Lead actors:* MoH, PO-RALG, MoF, IAG Office.
- **Align HBF processes with UHI claims systems** to prevent duplication and strengthen PHC financing coherence (see 5.2.5). *Lead actors:* MoH, NHIF, PO-RALG, DPs.

5.3.3 Institutional Adoption at Policy Level

Objective: Secure the long-term sustainability of HBF reforms by embedding them into national policy, planning frameworks, and the health financing architecture.

Key Actions:

- **Incorporate the fund flow monitoring dashboard** and interoperability standards into official MoH and PO-RALG operational guidelines and public financial management (PFM)

regulations, with earmarked resources for system maintenance and updates (see 5.2.1 and 5.2.4). *Lead actors:* MoH, MoF, PO-RALG.

- **Revise the Health Basket Fund Operational Guidelines** to explicitly reflect updated equity allocation formula rules, guaranteed base allocations, flexibility provisions, and digital reporting standards (see 5.2.2, 5.2.3, 5.2.4).
- **Strengthen the role of CHMTs and RHMTs** in HBF performance monitoring, with updated terms of reference and clear escalation procedures for underperformance (see 5.2.7). *Lead actors:* MoH, PO-RALG, RHMTs.
- **Integrate HBF–UHI complementarity** into the National Health Financing Strategy and multi-year PHC financing roadmap, ensuring donor contributions and public financing streams are aligned to protect core PHC functions and equity goals (see 5.2.5 and 5.2.6).
- **Operationalize the harmonization measures** outlined in 3.9.6 and reinforced in 4.3 by revising national expenditure rules so that facility plans and budgets in FFARS and PlanRep can fully integrate HBF, UHI, and other financing sources into a single, comprehensive framework. This should ensure that allocation decisions are driven by service priorities across promotive, preventive, curative, and administrative areas, rather than by the source of funds. Lead actors: MoH, MoF, PO-RALG.
- **Secure long-term domestic and partner financing commitments for PHC**, embedded in the PHC financing roadmap, to maintain HBF's role as an equity-focused platform alongside UHI. *Lead actors:* MoH, MoF, PO-RALG, DPs.
- **Institutionalize UHI uptake and financial flow monitoring** by embedding the tools developed under 5.2.5 into national health information systems, with LGA-level access for routine oversight. Ensure these data inform annual planning, equity allocation adjustments, and joint HBF–UHI performance reviews.

Overall synthesis: By following the three-stage pathway of innovation, integration, and institutionalization, and assigning clear lead actors for each step, Tanzania can systematically embed the reforms from 5.2 into national systems and practice. This sequenced approach ensures that innovations are tested, embedded in routine operations, and secured within policy and financing frameworks, creating a resilient HBF architecture that complements UHI and broader health sector reforms.

5.4 Reflections against OECD-DAC Evaluation Criteria

This section synthesizes the overall performance of the Health Basket Fund (HBF) through the lens of the OECD-DAC evaluation criteria. While Section 3.13 provides a summary of findings with detailed references, this section draws strategic implications for HBF reform and partner engagement.

5.4.1 Relevance

The HBF remains highly relevant to Tanzania's health sector goals and UHC commitments. Its alignment with the Health Sector Strategic Plan (HSSP V) and its focus on PHC delivery position it as a key vehicle for equitable health access. The Fund's embeddedness in government systems further strengthens its policy relevance. However, evolving health financing reforms — including the rollout of UHI — call for re-clarification of HBF's complementary role in financing public health goods and services not covered by insurance.

Strategic implication: Safeguard the relevance of the HBF by formally embedding its role in financing non-insurable PHC functions and underserved areas into the **National Health Financing Strategy** and **PHC financing roadmap** (see 5.2.5, 5.3.3), ensuring complementarity with UHI.

5.4.2 Effectiveness

The HBF has facilitated substantial improvements in PHC delivery, institutional capacity, and financial decentralization. However, disbursement delays, rigid spending rules, and unaligned performance indicators constrain its full potential. The disconnect between planning and disbursement cycles further undermines local execution capabilities.

Despite important strides in decentralizing decision-making to the facility level through DHFF, the MTR found that intermediate governance layers - particularly CHMTs and RHMTs - remain insufficiently empowered to systematically address underperformance or promote peer learning. Strengthening the effectiveness of the HBF architecture therefore requires stronger supervisory mandates, sufficient resourcing, and targeted capacity building.

Strategic implication: Enhance HBF effectiveness by implementing timely and predictable disbursements (see 5.2.1, 5.3.2), refining equity allocation rules (5.2.2, 5.3.1), and strengthening CHMT/RHMT oversight roles in line with updated HBF Operational Guidelines (5.3.3).

5.4.3 Efficiency

Administrative workloads, parallel reporting systems, and fragmented fund flow mechanisms reduce operational efficiency. The absence of harmonized IT systems and duplicate data entry obligations creates unnecessary transaction costs at both facility and LGA levels.

Strategic implication: Improve efficiency by achieving full interoperability of core planning, budgeting, and reporting systems (5.2.4, 5.3.2), scaling up integrated workflows for financial and service planning, and institutionalizing the digital fund flow monitoring dashboard as a core PFM tool (5.2.1, 5.3.3).

5.4.4 Impact

The HBF has made significant contributions to PHC infrastructure, community participation, and local accountability structures such as Health Facility Governing Committees (HFGCs). However, impact measurement is constrained by inadequate outcome-level monitoring and fragmented reporting tools.

Strategic implication: Increase impact by aligning performance metrics with equity and service delivery goals (5.2.2, 5.3.1), integrating financial and service data into supervision dashboards (5.2.7, 5.3.2), and embedding regular outcome monitoring into the Joint Health Sector Review (5.3.3).

5.4.5 Sustainability

The sustainability of HBF-supported interventions is threatened by overreliance on external funding and the absence of a defined transition plan in the context of UHI reforms. While UHI offers new fiscal and institutional opportunities, it may risk crowding out public PHC funding without deliberate safeguards.

Strategic implication: Secure sustainability by developing a joint HBF - UHI financing roadmap that protects equity-sensitive PHC services (5.2.5, 5.3.3), maintains earmarked public funding for preventive and promotive functions, and includes a phased plan for increasing domestic resource mobilization.

5.4.6 Coherence

The HBF's alignment with national priorities and sector coordination structures is a key strength. Yet, coherence with vertical programs and other financing modalities (e.g., insurance reimbursements) remains partial. Lack of interoperability across financial and monitoring systems impedes coordinated decision-making.

Strategic implication: Strengthen coherence by codifying interoperability standards and joint reporting requirements into official guidelines (5.3.3), aligning HBF planning and reporting cycles with UHI and vertical programs, and using the digital fund flow dashboard and integrated reporting platforms as shared monitoring tools.

Overall synthesis: Taken together, these reflections highlight the HBF's enduring relevance and potential for greater impact, while underscoring the urgency of embedding operational reforms into policy and financing frameworks. By implementing the reforms set out in 5.2 and sequencing them through the innovation–integration–institutionalization pathway in 5.3, Tanzania can ensure the HBF evolves into a fully integrated, transparent, and equitable PHC financing platform that remains central to achieving UHC in the UHI era. This is consistent with international evidence (see 3.13), where countries aligning PHC financing and reporting systems at national scale have achieved both higher efficiency and stronger equity outcomes.

5.5 Priority Actions & Next Steps

This section distils the MTR's detailed recommendations (Section 5.2) and phased roll-out pathway (Section 5.3) into a concise set of priority actions for the next 12–18 months. The aim is to provide decision-makers with a clear implementation checklist, assigning lead responsibility and linking each action to the relevant recommendations for ease of follow-up.

Priority Actions

1. **Develop and launch the fund-flow monitoring dashboard** to improve timeliness, transparency, and accountability of HBF disbursements. *Lead actors:* MoH, PO-RALG, MoF; *Timeline:* Design and pilot within 6 months; *Ref:* 5.2.1, 5.3.1–5.3.2.
2. **De-risk Q1 disbursements** by finalizing the **IAG Terms of Reference by December** and applying a staggered release model - initial tranches based on approved plans and budgets, with subsequent releases contingent on audit verification. *Lead actors:* IAG Office, MoF, MoH; PO-RALG *Timeline:* Annual cycle; *Ref:* 5.2.1, 5.3.2.
3. **Operationalize equity allocations** by embedding the base allocation and targeted equity window into annual planning and budgeting, with clear disbursement, reporting, and accountability mechanisms. *Lead actors:* MoH, PO-RALG, MoF; *Timeline:* Next planning cycle; *Ref:* 5.2.2, 5.3.1–5.3.2.
4. **Enable facility-level reallocation flexibility** within approved cost centres, with simple accountability rules and training on adaptive budgeting principles. *Lead actors:* MoH, PO-RALG, CHMTs; *Timeline:* Before next fiscal year; *Ref:* 5.2.3, 5.3.2.
5. **Complete digital interoperability** of FFARS, PlanRep, GoTHOMIS, eLMIS, NHIF/UHI via the Muungano Gateway and Health Information Mediator, enabling a single data workflow for planning and reporting. *Lead actors:* MoH Digital Health, PO-RALG ICT, NHIF, MoF; *Timeline:* 12–18 months; *Ref:* 5.2.4, 5.3.2.

6. **Clarify HBF - UHI complementarity** within a multi-year PHC financing roadmap, ensuring HBF safeguards equity-sensitive and non-insurable PHC functions. *Lead actors:* MoH, MoF, NHIF; *Timeline:* Within 12 months; *Ref:* 5.2.5, 5.3.3.
7. **Strengthen CHMT and RHMT mandates** for supportive supervision, including updated ToRs, escalation protocols, and adequate operational resources. *Lead actors:* MoH, PO-RALG, RHMTs, CHMTs; *Timeline:* Next FY workplans; *Ref:* 5.2.7, 5.3.2–5.3.3.
8. **Institutionalize reforms** by updating HBF Operational Guidelines, MoH/PO-RALG planning manuals, and JHSR agendas to reflect new allocation rules, digital tools, and accountability processes. *Lead actors:* MoH, PO-RALG, MoF; *Timeline:* Within 12 months; *Ref:* 5.3.3.

Monitoring Arrangements

Progress on these actions should be tracked quarterly through the fund-flow monitoring dashboard (5.2.1) and integrated reporting platforms (5.2.4), reviewed at CHMT/RHMT meetings, and presented as a standing item at the Joint Health Sector Review. Each action should be accompanied by a simple traffic-light status, responsible unit, and key risks to ensure accountability.

Overall synthesis:

These priority actions provide a clear bridge between the MTR's strategic recommendations and tangible implementation commitments. Sequencing them through the innovation → integration → institutionalization pathway outlined in 5.3 will ensure the HBF evolves into a fully integrated, transparent, and equitable PHC financing platform that complements UHI and supports Tanzania's UHC goals. The sequencing and focus areas proposed also reflect proven strategies from peer countries outlined in 3.13, adapted to Tanzania's institutional context and fiscal architecture.

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7. MAIN TABLES

Table 9: Regional level funding, amounts in million TZS, 2021/22-2023/24

Source of Funds	Dar es Salaam (%)	Arusha (%)	Mwanza (%)	Kigoma (%)	Dodoma (%)	Katavi (%)	Iringa (%)	Mtwara (%)	Songwe (%)
Basket Fund	413.8(38.3)	288.7(62.1)	208.4(21.1)	457.1(13.9)	476.1(27.8)	426.5(24.9)	385.5(16.8)	515.6(27.8)	255.0(20.7)
OC Proper	224.1(20.7)	152.1(32.7)	263.6(26.7)	148.4(4.5)	201.2(11.8)	-	198.6(8.6)	223.2(12.0)	105.6(8.6)
Global fund	152.4(14.1)	23.9(5.1)	144.4(14.6)	33.7(1.0)	87.2(5.1)	120.5(7.0)	30.8(1.3)	-	323.8(26.2)
World Bank	-	-	-	-	103.3(6.0)	615.6(35.9)	285.3(12.4)	-	-
WHO	-	-	20.6(2.1)	-	-	66.6(7.0)	-	125.2(6.7)	-
UNICEF	290.9(26.9)	-	10.0(1.0)	2,482.4(75.3)	168.6(9.9)	296.4(35.9)	1,145.7(49.9)	883.1(47.6)	466.5(37.8)
Result Based Financing	-	-	-	82.3(2.5)	-	-	-	-	-
JHPIEGO	-	-	45.0(4.6)	-	-	-	-	-	-
DFID	-	-	-	-	428.6(25.0)	-	-	-	-
EGPAF	-	-	-	-	84.6(4.9)	-	-	-	-
Nutrition International	-	-	-	-	-	-	-	5.3(0.3)	-
DELLOITE	-	-	-	-	-	-	138.2(6.0)	-	-
USAID Boresha Afya	-	-	-	-	-	-	-	10.9(0.6)	-
GGAVI	-	-	18.4(1.9)	93.50(2.8)	147.96(8.6)	188.61(11.0)	114.16(5.0)	80.8(4.4)	83.0(6.7)
Sustainable Rural water	-	-	277.3(28.1)	-	-	-	-	-	-
IMMA	-	-	-	-	13.48(0.8)	-	-	12.8(0.7)	-
Total	1,081(100)	465(100)	988(100)	3,297(100)	1,711(100)	1,714(100)	2,298(100)	1,857(100)	1,234(100)

Note: The lack of information in the table is due to the inability to retrieve data from the financial information systems during the facility visit (no electricity, internet connectivity issues, and the responsible person was not present). Values in brackets represents proportions.

Table 10: Council level funding, amounts in million TZS, 2021/22-2023/24

Source of fund	Dar es Salaam CC (%)	Ubungo MC (%)	Arusha CC (%)	Meru DC (%)	Mwanza CC (%)	Ukerewe DC (%)	Kigoma/Ujiji MC (%)	Kasulu DC (%)	Namnyumbu DC (%)	Masasi TC (%)	Nsimbo DC (%)	Iringa MC (%)	Dodoma CC (%)	Busocha DC (%)	Mufindi DC (%)
Basket Fund	6,036.3(17.1)	6,575.2(79.4)	338.6(41.9)	256.0(17.6)	1,484.5(2.7)	1,763.4(25.0)	924.8(40.0)	2,233.2(25.0)	801.1(36.3)	489.7(8.9)	126.3(23.0)	244.4(19.2)	411.5(3.2)	1,688.5(27.5)	2,008.5(19.2)
OC Proper	-	-	285.2(35.3)	378.1(26.0)	-	-	338.1(14.6)	-	321.0(14.5)	340.0(6.2)	60.3(11.0)	386.5(30.3)	8,436.7(65.3)	209.8(3.4)	306.6(2.9)
Oncall	315.2(0.9)	-	183.7(22.7)	-	259.2(0.4)	111.1(2.0)	45.6(2.0)	85.4(1.0)	69.7(3.2)	112.2(2.0)	-	156.6(12.3)	-	62.7(1.0)	94.4(0.9)
Own source	8,713.3(24.6)	265.1(3.2)	-	138.9(9.5)	203.2(0.5)	-	-	181.5(2)	-	284.9(5.2)	34.0(6.2)	219.2(17.2)	3,302.1(25.5)	810.5(13.2)	2,638.8(25.3)
User Fees	16,452.3(46.5)	1,445.3(17.4)	-	-	50,886.8(91.4)	614.8(8.7)	586.4(25.4)	493.2(5.5)	651.4(29.5)	962.3(17.5)	-	-	-	644.6(10.5)	-
Global fund	-	-	-	28.7(2.0)	-	-	38.5(2.0)	-	-	-	-	24.0(2.0)	316.1(2.4)	17.4(0.3)	189.6(1.8)
UNICEF	-	-	-	174.4(12.0)	-	-	-	120.7(1.0)	-	-	-	108.2(8.5)	121.1(1.4)	16.0(0.3)	442.2(4.2)
Result Based Financing	-	-	-	-	-	-	-	33.1(0.4)	-	-	-	-	-	-	-
JHPIEGO	-	-	-	-	-	-	-	-	-	-	-	-	183.6(1.2)	-	-
EGPAF	-	-	-	141.5(9.7)	-	-	-	-	-	-	-	-	-	-	-
Nutrition International	-	-	-	-	-	2.2(0.03)	-	-	-	-	-	-	-	-	-
USAID Boresha Afya	-	-	-	-	-	-	-	-	-	-	-	3.7(0.3)	158.4(1.0)	-	-
WALTER REED	-	-	-	-	-	-	-	-	-	-	144.4(26.3)	-	-	-	-
ICHF	3,858.6(10.9)	-	-	-	86.7(0.2)	810.9(11.0)	-	406.5(5.0)	-	736.6(13.4)	-	-	-	100.3(2.0)	-
NHIF	-	-	-	-	580.8(1.0)	613.1(8.6)	308.7(13.3)	103.4(1.0)	153.1(6.9)	-	-	-	-	132.6(2.0)	-
DRF (Drugs Revolving Funds)	-	-	-	-	-	276.5(3.9)	-	-	96.3(4.4)	-	-	-	-	-	-
GAVI	-	-	-	122.2(8.4)	256.5(0.5)	178.6(2.5)	70.9(3.1)	105.4(9.9)	115.5(5.2)	29.1(0.5)	122.3(22.3)	131.4(10.3)	-	68.7(1.0)	-
Sustainable Rural water	-	-	-	88.3(6.1)	-	-	-	884.9(47.9)	-	-	60.9(11.1)	-	-	280.1(4.6)	361.5(3.5)
Centre Government Grants	-	-	-	126.6(8.7)	1,891.5(3.0)	2,719.5(38.4)	-	-	-	2,545.4(46.3)	-	-	-	2,110.2(34.4)	4,400.0(42.1)
Total	35,375.8 (100)	8,285.6(100)	807.5(100)	1,454.5(100)	55,649.2(100)	7,090.1(100)	2,312.9(100)	8,917.5(100)	2,208.1(100)	5,500.3(100)	548.2(100)	1,274.0(100)	12,929.4(100)	6,141.2(100)	10,441.7(100)

Note: The lack of information in the table is due to the inability to retrieve data from the financial information systems during the facility visit (no electricity, internet connectivity issues, and the responsible person was not present). Values in brackets represents proportions.

Table 11: Regional level activities, HBF amounts in million TZS, 2021/22-2023/24

Activities	Dar es Salaam		Mwanza		Kigoma		Dodoma		Katavi		Iringa		Mtwara		Songwe	
	Total funding	%	Total funding	%	Total funding	%	Total funding	%	Total funding	%	Total funding	%	Total funding	%	Total funding	%
Create an appropriate environment for private sector	1.8	0.4	11.7	2.9	0.00	0.0	4.1	0.9	-	0.0	1.0	0.3	9.6	1.9	14.14	5.1
Soliciti and mobilize financial resources for the RHMTs and CHMTs within the region	1.0	0.2	3.2	0.8	0.00	0.0	107.9	22.9	-	0.0	1.0	0.2	12.8	2.5	7.64	2.8
Conduct Supportive Supervision to CHMTs	103.5	25.6	144.0	35.5	0.00	0.0	74.1	15.8	3	29.1	14	36.1	132.2	25.8	98.96	35.7
Ensure provision of quality services in all councils	27.1	6.7	52.6	13.0	0.00	0.0	63.5	13.5	-	0.0	73.8	19.2	179.9	35.1	37.02	13.3
Plan and Report for RHMTs	132.6	32.7	67.3	16.6	0.00	0.0	-	0.0	-	0.0	67.0	17.4	74.1	14.5	14.1	5.1
Enhance Data Management and Operational Research	-	0.0	15.9	3.9	0.00	0.0	52.9	11.3	-	0.0	1.8	0.5	6.7	1.3	5.7	2.0
Coordinate Health, Social Welfare and Nutrition Services in the region	62.6	15.5	39.8	9.8	0.00	0.0	95.7	20.4	-	0.0	46.9	12.2	48.3	9.4	48.1	17.3
Support the Management of Human Resources for Health, Social Welfare and Nutrition	-	0.0	26.8	6.6	0.00	0.0	1.3	0.3	-	0.0	10.5	2.7	22.7	4.4	22.6	8.2
Develop inter-regional networking	18.9	4.7	15.0	3.7	97.47	100.0	3.6	0.8	7	70.9	11.5	3.0	-	0.0	2.8	1.0
Disseminate Policies, Regulations, Guidelines and Circulars	1.0	0.2	10.5	2.6	0.00	0.0	55.4	11.8	-	0.0	1.5	0.4	-	0.0	5.7	2.0
Facilitate emergency and disaster preparedness and response	2.5	0.6	18.5	4.6	0.00	0.0	11.8	2.5	-	0.0	14.3	3.7	-	0.0	14.1	5.1
Enhance Data Management and Operational Research	54.0	13.3	-	0.0	0.00	0.0	-	0.0	-	0.0	17.0	4.4	26.7	5.2	6.5	2.3
Total	404.9	100	405.4	100	97.5	100	470.3	100	10	100	385.5	100	512.9	100	277.4	100

Note: The lack of information in the table is due to the inability to retrieve data from the financial information systems during the facility visit (no electricity, internet connectivity issues, and the responsible person was not present).

Table 12: Council level activities, amounts in million TZS, 2021/22-2023/24

Activities	Ukerewe DC		Buchosa DC		Kigoma MC		Kasulu DC		Nsimbo DC		Iringa MC		Mufindi DC		Masasi DC		Nanyumbu DC	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Communicable Diseases and Priority Neglected Tropical Diseases & Zoonoses control	76.9	4.4	119.5	5.6	2.6	0.4	92.4	4.5	10.4	8.4	4.1	2.4	57.0	3.7	42.9	8.7	12.3	1.3
Community Health systems	75.0	4.3	727.3	34.3	0.0	0.0	102.7	5.0	8.3	6.7	0.0	0.0	16.7	1.1	3.1	0.6	15.2	1.7
Construction, rehabilitation and Planned Preventive Maintenance of physical Infrastructures of Health facilities and staff houses	24.0	1.4	25.4	1.2	1.6	0.3	92.4	4.5	-	0.0	0.0	0.0	80.6	5.2	10.6	2.2	66.2	7.2
Emergency preparedness and response	34.3	1.9	60.0	2.8	33.1	5.2	92.4	4.5	3.9	3.2	12.8	7.6	51.6	3.4	5.1	1.0	8.0	0.9
Environmental Health and Sanitation	94.4	5.4	25.9	1.2	37.6	5.9	92.4	4.5	6.8	5.5	3.2	1.9	108.9	7.1	19.5	4.0	6.2	0.7
Health commodities (Medicine, Medical equipment, medical and diagnostic supplies)	617.2	35.0	497.9	23.5	408.4	64.4	718.7	35.0	-	0.0	18.1	10.8	603.7	39.3	150.2	30.7	430.0	46.9
Strengthen Human Resources for Health management capacity for improved health services delivery	231.9	13.2	86.6	4.1	0.0	0.0	308.0	15.0	24.8	20.0	1.8	1.1	58.8	3.8	25.8	5.3	61.6	6.7
Non – Communicable Disease Control	36.4	2.1	52.6	2.5	19.2	3.0	92.4	4.5	5.0	4.1	0.0	0.0	52.7	3.4	12.5	2.5	3.7	0.4
Nutrition	90.4	5.1	28.1	1.3	0.0	0.0	92.4	4.5	10.1	8.2	12.9	7.7	92.3	6.0	22.6	4.6	10.9	1.2
Strengthen Organizational Structures and Institutional management at all levels	319.7	18.1	217.8	10.3	100.3	15.8	92.4	4.5	28.7	23.2	113.0	67.3	214.7	14.0	114.8	23.4	219.3	23.9
Reproductive, Maternal, Newborn, Child and Adolescent Health	102.4	5.8	213.4	10.1	30.3	4.8	92.4	4.5	19.9	16.1	0.0	0.0	104.6	6.8	78.7	16.1	79.8	8.7
Strengthen Social Welfare and Social Protection services	33.0	1.9	35.1	1.7	0.7	0.1	92.4	4.5	3.0	2.4	2.0	1.2	61.0	4.0	-	0.0	1.6	0.2
Traditional Medicine and alternative healing	27.9	1.6	32.0	1.5	0.0	0.0	92.4	4.5	3.0	2.4	0.0	0.0	34.3	2.2	4.1	0.8	2.5	0.3
Total	1,763.4	100	2,121.5	100	633.8	1.0	2,053.6	100	124.0	100	167.8	100	1,536.7	100	489.8	100	917.1	100

Table 13: Council level activities, amounts in million TZS, 2021/22-2023/24

Activities	Arusha CC		Meru DC		Dar es Salaam CC		Dar es Salaam CC		Dodoma CC		Nyamagana CC	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Communicable Diseases and Priority Neglected Tropical Diseases & Zoonoses control	5.7	9.2	2.0	0.8	0.0	0.0	-	0.0	1.7	0.5	80.6	5.2
Community Health systems	7.2	11.7	-	0.0	0.0	0.0	-	0.0	-	0.0	74.2	4.8
Construction, rehabilitation and Planned Preventive Maintenance of physical Infrastructures of Health facilities and staff houses	-	0.0	-	0.0	1529.1	42.0	1,529	42.0	-	0.0	14.8	1.0
Emergency preparedness and response	5.2	8.4	-	0.0	0.0	0.0	-	0.0	-	0.0	17.5	1.1
Environmental Health and Sanitation	19.3	31.5	1.4	0.5	131.2	3.6	131	3.6	-	0.0	100.8	6.6
Health commodities (Medicine, Medical equipment, medical and diagnostic supplies)	-	0.0	2.4	0.9	107.0	2.9	107	2.9	-	0.0	583.6	38.0
Strengthen Human Resources for Health management capacity for improved health services delivery	8.6	14.0	91.8	36.0	0.0	0.0	-	0.0	94.0	29.0	222.7	14.5
Non – Communicable Disease Control	-	0.0	1.4	0.5	1728.7	47.5	1,729	47.5	-	0.0	20.9	1.4
Nutrition	10.2	16.7	-	0.0	0.0	0.0	-	0.0	-	0.0	29.9	1.9
Strengthen Organizational Structures and Institutional management at all levels	-	0.0	146.4	57.4	0.0	0.0	-	0.0	167.4	51.7	197.7	12.9
Reproductive, Maternal, Newborn, Child and Adolescent Health	5.2	8.5	9.5	3.7	146.6	4.0	147	4.0	59.3	18.3	104.9	6.8
Strengthen Social Welfare and Social Protection services	-	0.0	-	0.0	0.0	0.0	-	0.0	0.8	0.2	73.4	4.8
Traditional Medicine and alternative healing	-	0.0	0.1	0.0	0.0	0.0	-	0.0	0.8	0.2	14.0	0.9
	61.3	100	255.0	100	3,642.4	100	3,642.4	100	323.9	100	1,534.9	100

Table 14: Health Facility Fund Carryover

Health Facility		Health Basket Fund				iCHF				Own source			
		2021-2022	2022-2023	2023-2024	Total	2021-2022	2022-2023	2023-2024	Total	2021-2022	2022-2023	2023-2024	Total
Hospital													
	Carried Over Fund	210.6	192.5	215.8	618.9	34.2	52.4	47.9	134.4	430.9	3,039.9	1,897.9	5,368.7
	Receipts/Allocation	663.0	1,940.2	2,963.6	5,566.8	416.2	363.6	422.2	1,202.1	4,266.3	1,788.4	2,368.2	8,422.9
	Total Funds	873.6	2,132.7	3,179.3	6,185.7	450.4	416.0	470.1	1,336.5	4,697.2	4,828.2	4,266.2	13,791.6
	Expenditure	838.4	1,936.8	2,738.0	5,513.2	365.3	403.3	429.2	1,197.9	1,660.8	2,926.2	3,932.8	8,519.9
	Balance	35.3	195.9	441.3	672.5	85.1	12.7	40.8	138.6	3,036.3	1,902.0	333.4	5,271.7
Health Centres													
	Carried Over Fund	81.7	84.6	100.3	266.5	13.3	14.2	2.8	30.2	-	0.6	0.6	1.2
	Receipts/Allocation	710.0	4,156.2	1,181.4	6,047.6	213.0	116.3	157.3	486.6	0.6	120.0	29.2	149.8
	Total Funds	790.6	4,178.5	1,282.7	6,251.8	226.3	130.5	160.1	516.8	0.6	120.6	29.8	151.0
	Expenditure	766.6	856.2	1,111.0	2,733.8	204.1	128.6	142.3	-	-	120.0	15.4	135.4
	Balance	24.0	3,322.3	171.7	3,518.1	22.2	1.9	17.8	516.8	0.6	0.6	14.4	15.7
Dispensary													
	Carried Over Fund	28.2	20.7	40.0	88.9	10.0	566.1	1.4	577.5	-	250.0	-	250.0
	Receipts/Allocation	76.7	131.7	825.8	1,034.3	25.3	10.4	12.5	48.2	250.0	-	15.0	265.0
	Total Funds	105.8	161.3	182.6	449.6	35.2	576.5	13.9	625.6	250.0	250.0	15.0	515.0
	Expenditure	94.3	108.5	118.9	321.7	23.7	20.0	12.0	55.7	-	250.0	15.0	265.0
	Balance	11.5	52.8	63.7	127.9	11.6	556.5	1.9	570.0	250.0	-	-	250.0

Table 15: Health Facility Fund Carryover

Health Facility		NHIF				Centre Government				User fee			
		2021-2022	2022-2023	2023-2024	Total	2021-2022	2022-2023	2023-2024	Total	2021-2022	2022-2023	2023-2024	Total
Hospital													
	Carried Over Fund	3.2	42.4	117.8	163.4	-	870.1	939.7	1,809.8	87.8	126.7	200.4	414.9
	Receipts/Allocation	889.3	1,401.5	2,201.4	4,492.1	1,264.5	3,083.2	3,006.2	7,353.9	2,234.0	2,601.1	4,669.1	9,504.2
	Total Funds	892.5	1,444.0	2,319.1	4,655.5	1,264.5	3,953.3	3,945.9	9,163.7	2,321.7	2,727.8	4,869.5	9,919.1
	Expenditure	849.8	1,329.5	1,905.7	4,084.9	428.9	2,792.9	3,499.2	6,721.0	2,135.1	2,228.1	4,567.1	8,930.3
	Balance	42.7	114.4	413.5	570.6	835.6	1,160.4	446.7	2,442.8	186.7	499.7	302.4	988.8
Health Centres													
	Carried Over Fund	25.1	34.0	47.0	106.1	-	306.0	949.1	1,255.1	260.8	414.7	299.7	975.1
	Receipts/Allocation	246.7	372.4	444.1	1,063.2	685.9	2,258.8	350.0	3,294.7	1,717.6	2,379.7	2,634.2	6,731.5
	Total Funds	254.4	404.5	484.9	1,143.7	685.9	2,564.8	1,299.1	4,549.8	3,238.9	2,672.6	2,933.9	8,845.5
	Expenditure	244.4	364.2	378.1	986.7	380.0	1,615.7	548.1	2,543.8	2,756.5	2,313.0	2,533.4	7,602.8
	Balance	10.0	40.3	106.8	157.1	306.0	949.1	751.0	2,006.0	482.5	359.7	400.5	1,242.6
Dispensary													
	Carried Over Fund	7.6	10.1	6.2	23.8	-	27.0	29.8	56.8	34.1	53.0	40.8	127.9
	Receipts/Allocation	21.9	26.0	25.3	73.3	62.2	-	25.0	87.2	132.7	117.1	179.5	429.2
	Total Funds	28.7	35.9	31.5	96.2	50.5	27.0	54.8	132.3	167.9	223.2	220.2	611.3
	Expenditure	19.5	30.1	6.1	55.6	23.1	22.9	20.2	66.1	134.8	127.4	163.7	425.9
	Balance	9.3	5.8	25.4	40.5	27.4	4.2	34.6	66.3	33.1	95.8	56.5	185.5

Table 16: Regional level - Service delivery outputs

	Dodoma			Mtwara			Dar Es Salaam			Mwanza		
Service delivery outputs	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
% of pregnant mothers attending first ANC visit (Under 20 years)	19	19	18	18	19	19	8	8	8	15	15	15
% of pregnant mothers attending first ANC visit (above 20 years)	81	82	82	82	81	81	92	93	92	85	85	85
% of pregnancy mothers at least attended at least 4 visits.	40	46	49	106	108	113	100	100	100	103	82	95
% of mothers who received 2 doses of intermittent preventive treatment (IPT2) for malaria during last pregnancy during ANC attendance.	88	93	100	89	79	91	113	118	108	77	79	73
% of ANC attendees receiving adequate quantity of Iron and Folate tablets until the next ANC visit	84	96	98	91	94	96	89	94	96	88	90	92
% of institutional deliveries coverage	85	83	87	96	96	96	61	63	68	90	92	92
% of women of reproductive age (15-49 years) using modern family planning methods, example of family planning	37	38	36	27	26	31	35	27	34	27	29	35
% of children breastfed within one hour of birth	94	95	94	90	89	88	85	84	85	88	89	91
% of newborn who received postnatal care within two days of birth.	86	93	94	90	89	88	83	87	86	81	83	87
% of pregnant women with severe anaemia	1	1	1	1	1	2	2	2	2	2	2	3
% of people living with HIV are aware of their status	80	83	96	65	74	80	81	87	92	85	87	98
% of Hypertension among in OPD	3	2	3	2	2	3	4	4	4	2	3	3
% of GBV and VAC survivors who have experienced any violence reporting within 72 hours after the incident	33	31	19	10	14	13	30	36	45	21	14	18
Number of TB Cases notified	176	245	245	2405	2474	2316	265	295	277	111	115	100

Table 17: Regional level - Service delivery outputs

Service delivery outputs	Iringa			Kigoma			Arusha			Katavi			Songwe		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
% of pregnant mothers attending first ANC visit (Under 20 years)	11	11	11	16	16	10	13	12	11	20	19	20	21	20	21
% of pregnant mothers attending first ANC visit (above 20 years)	89	89	89	84	85	90	87	88	89	80	81	80	79	80	79
% of pregnancy mothers at least attended at least 4 visits.	110	106	103	104	120	117	112	120	117	40	47	52			
% of mothers who received 2 doses of intermittent preventive treatment (IPT2) for malaria during last pregnancy during ANC attendance.	87	93	93	80	97	100	60	84	90	93	81	83	77	92	85
% of ANC attendees receiving adequate quantity of Iron and Folate tablets until the next ANC visit	87	91	95	90	97	94	88	95	98	87	92	92	60	78	86
% of institutional deliveries coverage	79	76	74	91	89	88	74	72	72	115	120	141	81	84	82
% of women of reproductive age (15-49 years) using modern family planning methods, example of family planning	76	64	68	30	38	51	36	46	47	47	50	50	26	21	21
% of children breastfed within one hour of birth	81	81	86	95	94	95	89	92	91	90	91	91	85	88	90
% of newborn who received postnatal care within two days of birth.	96	94	97	89	87	92	85	90	92	83	86	88	92	93	94
% of pregnant women with severe anaemia	1	0	0	1	1	1	2	1	1	1	1	2	0	0	0
% of people living with HIV are aware of their status	86	97	110	81	89	113	77	86	89	92	117	14	83	93	101
% of Hypertension among in OPD	4	4	5	2	2	2	5	5	5	1	2	2	2	2	2
% of GBV and VAC survivors who have experienced any violence reporting within 72 hours after the incident	43	37	36	37	54	54	24	32	36	20	40	40	49	48	57
Number of TB Cases notified	153	157	148	51	53	57	95	95	97	137	137	131	84	94	101

Note: Information for the empty cells was not obtained.

Table 18: Regional level - Health System Outputs for Improving Conditions for Quality of Care

Service delivery outputs	Dodoma			Mtwara			Dar Es Salaam			Mwanza		
Health System Outputs for Improving Conditions for Quality of Care	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
% of PHC facilities with “3 stars” rating or higher				0.2	0.2	0.2	57	77				
% of dispensaries that have their required staff (nurse/midwife and clinician)	33	31.2	19	10	13.7	13.2	30.3	36	45	20.6	13.8	18.2
% of availability of 30 tracer items (medicines, vaccines, medical devices) in the past year	83	83	85	90.8	94.5	90.9	100	100	100	100	100	96.6
% of HFs with functional Health Facility Governing Committees	100	100	100	100	100	100	100	100	100	100	100	100
Quarterly data quality audits (DQA) for LGAs conducted according to national DQA standards				100	88.8	50	100	100	100	100	100	100
% of Public health facilities with electronic medical records (EMR) for service delivery, tracking health commodities usage and health facility finances				100	100	100	54	79	84	20	25	29
% of RHMT’s conducted annual supportive supervision visits for LGAs that meets national supervision standards	100	100	100	100	100	100	100	100	100	100	100	100
% of CHMT’s conducted annual supportive supervision visits for LGAs that meets national supervision standards												
% of LGAs with unqualified opinion in the external audit report							100	100	100	100	100	100

Note: Information for the empty cells was not obtained.

Table 19: Regional level - Health System Outputs for Improving Conditions for Quality of Care

Service delivery outputs	Iringa			Kigoma			Arusha			Katavi			Songwe		
Health System Outputs for Improving Conditions for Quality of Care	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
% of PHC facilities with “3 stars” rating or higher															
% of dispensaries that have their required staff (nurse/midwife and clinician)	42.5	36.9	35.5	36.9	54.3	54.2	24.4	31.7	35.5	20	39.8	40.1	48.6	48.1	57.4
% of availability of 30 tracer items (medicines, vaccines, medical devices) in the past year	86	91	93	100	100	100				100	100	100	100	100	100
% of HFs with functional Health Facility Governing Committees	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Quarterly data quality audits (DQA) for LGAs conducted according to national DQA standards	50	75	100	100	100	100	14	14	14	100	100	100	100	100	100
% of Public health facilities with electronic medical records (EMR) for service delivery, tracking health commodities usage and health facility finances	35	35	35	100	100	100							100	100	100
% of RHMT’s conducted annual supportive supervision visits for LGAs that meets national supervision standards	100	100	100	100	100	100	100	100	100	99	99	99	100	100	100
% of CHMT’s conducted annual supportive supervision visits for LGAs that meets national supervision standards													100	100	100
% of LGAs with unqualified opinion in the external audit report	100	100	100	100	100	100				100	100	100	100	100	100

Note: Information for the empty cells was not obtained.

Table 20: Council level Service Delivery

		% of first ANC visit < under 20 years			% of first ANC visit > 20 years			% attended at least 4 ANC visits			% of mothers received 2 doses of IPT2 for malaria last ANC visit		
	Council Name	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Dodoma	Bahi DC	20	19	20	108	98.1	101	121	121	141	100	97	103
	Dodoma CC	13	13	12	87	87	87	105	138	146	70	104	108
Mwanza	Busocha DC	16	16	17	84	84	83	72	67	65	67	72	68
	Ukerewe DC	11	13	13	89	87	87	84	84	76	56	80	61
	Mwanza City	10	10	10	89	90	90	123	128	144	78	83	78
Iringa	Mufindi DC	11	10	11	89	90	89	96	89	87	96	106	96
	Iringa MC	9	9	9	91	91	91	100	100	100	67	77	87
Kigoma	Kasulu DC	191	17	12	81	83	88	160	151	162	101	95	101
	Kigoma/Ujiji MC	12	14	8	87	86	92				99	105	119
Arusha	Arusha CC	7	8	9	90	80	90	93	92	92	83	102	92
	Meru DC	10	10	10	89	90	89	97	108	115	85	91	97
Katavi	Nsimbo DC	18	17	18	82	83	82	99	99	99	108	96	90
	Mpanda MC	17	16	16	83	84	84	37	38	47	97	83	76
Mtwara	Masasi TC	18	18	18	82	82	82	139	143	139	92	84	80
	Nanyumbu DC	23	26	24	77	74	75	113	123	116	93	97	94
Songwe	Ileje DC	19	20	19	81	80	81	56	68	62	98	93	105
Dar es Salaam	Dar es Salaam CC	6	6	6	94	93	94	98	99	99	74	76	106
	Ubungo MC	7	7	7	93	93	93	141	148	150	88	96	99

Note: Information for the empty cells was not obtained.

Table 21: Council level service delivery (contd.)

		% receiving Iron and Folate tablets until the next ANC visit			% of institutional deliveries coverage			% of women (15-49 years) using modern family planning			% children breastfed within one hour of birth		
	Council Name	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Dodoma	Bahi DC	93	107	97	87	86	88	83	84	84	97	98	98
	Dodoma CC	68	93	97	97	97	97	37	49	41	82	88	90
Mwanza	Busocha DC	94	96	88	81	79	78	16	19	24	91	91	94
	Ukerewe DC	77	82	86	72	68	65	35	55	51	86	93	88
	Mwanza City	96	91	92	122	138	135	35	40	46	89	80	86
Iringa	Mufindi DC	89	89	97	97	99	99	54	34	35	83	84	89
	Iringa MC	81	90	93	100	100	100	35	27	32	68	76	86
Kigoma	Kasulu DC	99	99	96	123	109	102	38	51	53	97	94	98
	Kigoma/Ujiji MC	113	103	94	98	99	99				97	93	95
Arusha	Arusha CC	101	100	103	100	102	101	54	55	56	102	90	103
	Meru DC	85	90	95	55	53	53	21	27	39	84	96	97
Katavi	Nsimbo DC	95	99	94	79	82	88	46	39	41	6	96	96
	Mpanda MC	79	78	89	152	159	162	37	51	46	84	87	86
Mtwara	Masasi TC	104	98	93	101	101	110	17	11	11	82	99	91
	Nanyumbu DC	98	98	100	68	68	69	29	33	34	87	89	87
Songwe	Ileje DC	84	88	95	47	49	50	23	20	25	86	87	84
Dar es Salaam	Dar es Salaam CC	88	92	94			99	78	78	79	80	82	81
	Ubungo MC	90	100	100	79	77	84						

Note: Information for the empty cells was not obtained.

Table 22: Council level service delivery (contd.)

		% new-born who received postnatal care within two hours of birth			% of pregnant women with severe anaemia			# of TB cases notification rate			% of people living with HIV are aware of their status		
	Council Name	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Dodoma	Bahi DC	98	96	98	0.6	0.5	1	169	229	202	95	96	97
	Dodoma CC	60	79	89	1.3	1.8	1.6	1176	1653	1724	80	84	85
Mwanza	Busocha DC	96	86	90	1.5	1.5	1.5	51	53	45	76	74	
	Ukerewe DC	69	62	63	1.6	1.6	3.2	360	275	206	93	86	85
	Mwanza City	90	80	86	3	2.4	3	274	297	257	89	99	90
Iringa	Mufindi DC	88	84	89	0.3	0.2	0.2	77	68	68	76	82	88
	Iringa MC	98	105	98	1	0.8	0.9	328	362	322	114	126	
Kigoma	Kasulu DC	83	93	92	0.3	0.2	0.3	52	47	43	81	97	
	Kigoma/Ujiji MC				0.7	1.8	1.8	99	99	99	87	100	
Arusha	Arusha CC	90	92	94	2	1	0.6	99	192	196	3	2	2
	Meru DC	87	88	97	1.5	1.4	1.5	125	129	125	64	76	94
Katavi	Nsimbo DC	95	94	94	2	13	2.6	74	72	66	61	141	99
	Mpanda MC	54	85	80	0.9	0.8	1.1	264	257	287	125	124	123
Mtwara	Masasi TC	81	81	84	1.1	0.9	2.2	86	75	86	82	88	95
	Nanyumbu DC	65	65	65	0.4	1.3	3.2				73	64	74
Songwe	Ileje DC	92	88	93	0.3	0.3	0.6	41	41	44	70	60	95
Dar es Salaam	Dar es Salaam CC	80	86	84	3.3	2	1.8	1	1	1	44	42	40
	Ubungo MC	43	43	47				184	120	187	70	60	

Note: Information for the empty cells was not obtained.

Table 23: Information on GBV/VAC, Staff, Tracer Items and Supportive Supervision

		GBV and VAC survivors who have experienced any violence reporting within 72 hours after the incident			% dispensaries that have their required staff (nurse/midwife and clinician)			% PHC facilities with continuous availability of 30 tracer items (medicines, vaccines, medical devices)			% of RHMT's conducted annual su supervision visits for LGAs		
	Council Name	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Dodoma	Bahi DC	45	40	11	100	100	100	100	100	98	100	100	100
	Dodoma CC	18	42	38	100	100	100	95	96	97			
Mwanza	Busocha DC	57	17	20	98	98	98	91	90	92	75	88	90
	Ukerewe DC	27	11	12	89	89	100	93	93	100			
	Mwanza City	24	24	26	100	100	100	95	93	96	100	100	100
Iringa	Mufindi DC	58	58	30	89	90	91	94	95	95	50	50	50
	Iringa MC	16	21	22	65	65	65	100	100	100			
Kigoma	Kasulu DC	39	32	31	100	100	100	100	100	99	100	100	100
	Kigoma/Ujiji MC				50	56	60	100	100	100	70	70	70
Arusha	Arusha CC	88	71	75	100	100	100	100	100	100			
	Meru DC	15	14	36	54	54	55				100	100	100
Katavi	Nsimbo DC	28	58	59	45	65	75	85	85	95	85	85	90
	Mpanda MC	11	18	14	100	100	100	100	100	100	100	100	100
Mtwara	Masasi TC	6	7	26	100	100	100	97	98	97			
	Nanyumbu DC	14	26	16	95	100	100						
Songwe	Ileje DC	8	5	20	100	100	100	100	100	100	100	100	100
Dar es Salaam	Dar es Salaam CC	40	62	66	75	76	76	98	98	98			
	Ubungo MC	28	26.8	54	98	99	99	97	99	100			

Note: Information for the empty cells was not obtained.

Table 24: Health Facility level Indicators

COUNCIL NAME	FACILITY NAME	% of pregnant mothers attending first ANC visit (< 20 years)			% of pregnant mothers attending first ANC visit (> 20 years)			% of pregnancy mothers at least attended at least 4 visits.			% of mothers who received 2 doses of intermittent preventive treatment (IPT2) for malaria during last pregnancy during ANC			% of ANC attendees receiving adequate quantity of Iron and Folate tablets until the next ANC visit			% of institutional deliveries coverage		
		2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Ilala	Kivule Hospital	7.2	7.5	8.2	104	194	106	119	132	252	67	85	100.7	100	100	100	71.3	72	219
	Pugu Kajiungeni	8	8.8	7.8	92	91.2	92.2	339.8	387	263.9	77	87	97	100	96.4	103.1	541.8	548.2	454.5
	Gerezani	13.7	14.2	14.5	68.9	71.5	83.7	119.7	130.8	135.6	86	117	161	100	100	100			
Ubungo	Ubungo District	6.9	5.1	5.1	90.1	94.9	93.9					82	111		105	103.5			
	Kimara	7.1	6.2	5.9	92.9	93.8	94.1				86	67	79	101.1	100	99.7			
	Mpiji Magoe	7.7	8.6	9.5	92.3	91.4	90.5				67	86	106	122.5	100.4	100			
Arusha City	Arusha City	8.4	11.5	7.2	91.6	88.5	92.8				46	56	153	80	102.3	99.2			
	Kaloleni	6.8	5.8	6.7	93.2	94.2	93.3				18	68	85	100.4	101.6	99.99			
	Nadosoito	99.9	75	94	90.1	92.5	90.6	0	0	0	71	47	74	93.3	0	95.8	0	0	0
Meru DC	Meru District	7.1	6.9	6.7	92.4	93.1	93.3	392	447	423	79	93	114	84	98.9	99.6	457	460	438
	Usa River	10.3	8.9	9.5	89.7	91.1	90.5	50.8	48.5	48.4	78	79	79	100.1	99.3	100.9	98.7	98.1	98.6
	Maji ya Chai	12.4	12.8	12.5	87.6	87.2	87.5	160	205	188	69	105	91	58.3	89.2	70.5	23.9	20	8.5
Nyamagana (Mwanza City)	Nyamagana District	10.2	10.1	10.1	90	90	90	23.8	25.9	26.2	56.2	64.3	60.2	81.1	66	84.7	98.6	97.9	98.1

	Makongoro	9.9	12.2	10.6	90	87.8	89.3	28.3	41.5	44.8	75	76	92	69	100	92	23.3	37.7	66.1
	Buhongwa	9.7	10.5	9	90.3	89.5	91	174.3	174.8	188.8	74	105	123	69.3	82	92.8	49.7	54.1	74.4
Ukerewe	Nansio District	11.3	13.2	11.2	88.7	86.8	88.8	148.1	106.7	134.9	63	65	71	111	105.5	85	462	454.2	439.3
	Kanguguli	12.5	14.1	14.9	87.5	85.9	85.1	30.59	22.1	33.2	21	66	50	59.9	61.1	43	116.7	108.6	137.1
	Namagondo	3.6	4.6	8.6	47.4	33.7	44.2	45.1	34	42.7	16	20	18	42	47	51.8	60	66	59
Busocha DC	Buchosa District Hospital	13.5	18.3	19	86.5	81.7	81	72.4	67.5	64.8	83	80	80	72.3	107	94	98.7	67.8	371
	Nyehunge	14	15.2	16.5	86	84.8	83.3	96.8	99.3	106	48	74	70	74.6	122.8	104.4	90.7	99.4	99.7
	Sukuma	19.5	18.1	22.1	80.5	81.9	77.9	29.9	32.9	20.4	87	97	26	91	110.3	28.3	97.3	95.1	97.3
Kigoma/ Ujiji MC	Ujiji Health Centre	96	92	94	91	100	53	98	96	100	90	92	95			100	98	98	
	Gungu	13.2	14	9.2	86.8	86	90.8	109	160.3	156	103	125	95	125.3	99.9	104.3	94.1	99.5	99.5
	Msufini	9.9	14.2	7.7	90.1	85.8	92.3	104	77	136	97	51	157	102	97.4	107.3	0	0	0
Kasulu DC	Kasulu District	16.1	12.6	11	83.9	87.4	89	0	0	0	100	86	145	100.6	94.9	99.9	0	0	0
	Kimwanya	12.1	16.8	15.5	87.9	83.2	84.5	55	46		100	101	91	100	98.1	107.3			
	Rungwe Mpya	16.6	15	9.7	83.4	85	90.3	22.4	33.7		100	81	89	99.8	99.6	103.5	77.9	120.6	67
Dodoma City	St.Gemma	4.4	4.2	3.5	95.6	95.8	96.5				62	79	70	108.6	115.5	104.3			70
	St.Gemma	13.5	20	14.9	82.3	80	85.1				91	91	83	93.3	102	100.5			
	Makole HC	10.2	10.1	9.7	89.8	89.9	90.3	108.05	109.74	174.84	121	131	117	69.8	97.2	98.7	94.4	94.6	95.6
	Nghonghonha	22.9	18.6	16.8	77.1	81.4	83.2				75	104	88	97.2	99.9	91.2	97.4	97.9	99.7
Bahi DC	Bahi Distric		16.7	11.8		83.3	88.2		111.2	268.8		83.3	88.2		258.9	97.6		133.3	107.2
	Mundemu	12.7	23.9	22.4	192	156	239	285	288	351	86	115	106		95	100	166.6	132.9	185.4
	Chonde			22.6			82	0.99		167			116			100			25.9

Mpanda MC	Mpanda District			12.8			87.2						78			93.8			0
	Ilembo	14.5	13.4	12.9	85.5	86.6	87.1	36	40	60	119	90	90	88.9	90	98.5			
	Milala	23.2	15.7	17.2	76.8	84.3	82.8	76.8	84.3	82.8	157	106	89	114.1	106	138.8			
Nsimbo DC	Nsimbo District		18.1	18.3		81.9	81.7					138	80		97.4	98.9			
	Katumba	13.9	6.8	10.3	86.1	93.2	89.8				74	84	91	93.7	115.4	101.5			
	Mtapenda	20.5	16.8	16.8	79.5	83.2	83.2				106	93	95	98.6	111.5	100.6			
Iringa MC	Iringa District	9.1	8.2	10.1	90.1	91.8	89.9	75.1	80.5	89.9	111	103	114	100	99.9	100	98.9	98.9	98.9
	Ipogoro	9.4	12.5	11.7	90.6	87.5	88.3				58	87	104	84.1	99.9	98.4			
	Nduli	14.4	17.4	16.6	85.6	82.6	83.4				125	145	94	105.5	88.3	68.6			
Mufindi	Mufindi District	4.3	6	8.9	95.6	94	91.1	25	36.7	46.5	37	94.1	80	90.1	83	81	100	93.4	100
	Kasanga	0.4	1.1	1	99.6	98.9		75	75	65	90	97		96.7	91	97	98.9	100	100
	Chogo	18.8	11.4	13.3	81.3	88.6	86.7	95.9	89.4	87.3	56	61	87	77.8	75.4	119.3	94.1	100	100
Masasi TC	Mkomaindo District	16.5	13	14.8	83.5	87	85.2	48.7	37.3	40	116	91	79	124.5	101.4	106.8	95.9	95.8	96.4
	Mtandi	0	0	9.8	0	0	90.2	0	0	30	0	0	94	0	0	105.8	0	0	66.7
	Makulani	24.7	27.5	27.9	75.3	72.5	72.1	33	29.2	25.6	71	111	100	100	104.4	100.3	93.9	95.9	94.3
Nanyumbu DC	Mangaka District	19.7	22.3	16.6	80.3	77.7	83.4	0	0	0	101	76	84	79.1	9.4	106.9	0	0	0
	Mtambaswala	30.3	28.2	28.5	79.7	71.8	71.5				111	114	142	83.1	97.5	102.2			
	Masuguru	25	15.7	25.1	74.1	40	35.1	81	70	65.3	36	41	78.01	90	65	80			
Ileje DC	Ileje District hospital	17.2	9.9	13.2	82.8	90.1	86.8	80	87	69	97	116	109	128.8	146.3	114.3			
	Ngulugulu	19.7	22.4	21.4	80.3	77.6	78.6				93	102	103	102	89.2	100.6			
	Ngulugulu			8.3			91.7						17			110			

Note: Information for the empty cells was not obtained.

Table 25: Health Facility level Indicators – average values (2021 – 2023)

COUNCIL NAME	FACILITY NAME	% of pregnant mothers attending first ANC visit (< 20 years)	% of pregnant mothers attending first ANC visit (> 20 years)	% of pregnancy mothers at least attended at least 4 visits.	% of mothers who received 2 doses of intermittent preventive treatment (IPT2) for malaria during last pregnancy during ANC	% of ANC attendees receiving adequate quantity of Iron and Folate tablets until the next ANC visit	% of institutional deliveries coverage
Ilala	Kivule Hospital	7.6	134.7	167.7	84.2	100.0	120.8
	Pugu Kajiungeni	8.2	91.8	330.2	87.0	99.8	514.8
	Gerezani	14.1	74.7	128.7	121.3	100.0	0.0
Ubungo	Ubungo District	5.7	93.0	0.0	64.3	69.5	0.0
	Kimara	6.4	93.6	0.0	77.3	100.3	0.0
	Mpiji Magoe	8.6	91.4	0.0	86.3	107.6	0.0
Arusha City	Arusha City	9.0	91.0	0.0	85.0	93.8	0.0
	Kaloleni	6.4	93.6	0.0	57.0	100.7	0.0
	Nadosoito	89.6	91.1	0.0	64.0	63.0	0.0
Meru DC	Meru District	6.9	92.9	420.7	95.3	94.2	451.7
	Usa River	9.6	90.4	49.2	78.7	100.1	98.5
	Maji ya Chai	12.6	87.4	184.3	88.3	72.7	17.5
Nyamagana (Mwanza City)	Nyamagana District	10.1	90.0	25.3	60.2	77.3	98.2
	Makongoro	10.9	89.0	38.2	81.0	87.0	42.4
	Buhongwa	9.7	90.3	179.3	100.7	81.4	59.4
Ukerewe	Nansio District	11.9	88.1	129.9	66.3	100.5	451.8
	Kanguguli	13.8	86.2	28.6	45.7	54.7	120.8
	Namagondo	5.6	41.8	40.6	18.0	46.9	61.7
Busocha DC	Buchosa District Hospital	16.9	83.1	68.2	81.0	91.1	179.2
	Nyehunge	15.2	84.7	100.7	64.0	100.6	96.6
	Sukuma	19.9	80.1	27.7	70.0	76.5	96.6

Kigoma/Ujiji MC	Ujiji Health Centre	94.0	81.3	98.0	92.3	33.3	65.3
	Gungu	12.1	87.9	141.8	107.7	109.8	97.7
	Msufini	10.6	89.4	105.7	101.7	102.2	0.0
Kasulu DC	Kasulu District	13.2	86.8	0.0	110.3	98.5	0.0
	Kimwanya	14.8	85.2	33.7	97.3	101.8	0.0
	Rungwe Mpya	13.8	86.2	18.7	90.0	101.0	88.5
Dodoma City	St.Gemma	4.0	96.0	0.0	70.3	109.5	23.3
	St.Gemma	16.1	82.5	0.0	88.3	98.6	0.0
	Makole HC	10.0	90.0	130.9	123.0	88.6	94.9
	Nghonghonha	19.4	80.6	0.0	89.0	96.1	98.3
Bahi DC	Bahi Distric	9.5	57.2	126.7	57.2	118.8	80.2
	Mundemu	19.7	195.7	308.0	102.3	65.0	161.6
	Chonde	7.5	27.3	56.0	38.7	33.3	8.6
Mpanda MC	Mpanda District	4.3	29.1	0.0	26.0	31.3	0.0
	Ilembo	13.6	86.4	45.3	99.7	92.5	0.0
	Milala	18.7	81.3	81.3	117.3	119.6	0.0
Nsimbo DC	Nsimbo District	12.1	54.5	0.0	72.7	65.4	0.0
	Katumba	10.3	89.7	0.0	83.0	103.5	0.0
	Mtapenda	18.0	82.0	0.0	98.0	103.6	0.0
Iringa MC	Iringa District	9.1	90.6	81.8	109.3	100.0	98.9
	Ipogoro	11.2	88.8	0.0	83.0	94.1	0.0
	Nduli	16.1	83.9	0.0	121.3	87.5	0.0
Mufindi	Mufindi District	6.4	93.6	36.1	70.4	84.7	97.8
	Kasanga	0.8	66.2	71.7	62.3	94.9	99.6
	Chogo	14.5	85.5	90.9	68.0	90.8	98.0
Masasi TC	Mkomaindo District	14.8	85.2	42.0	95.3	110.9	96.0
	Mtandi	3.3	30.1	10.0	31.3	35.3	22.2

	Makulani	26.7	73.3	29.3	94.0	101.6	94.7
Nanyumbu DC	Mangaka District	19.5	80.5	0.0	87.0	65.1	0.0
	Mtambaswala	29.0	74.3	0.0	122.3	94.3	0.0
	Masuguru	21.9	49.7	72.1	51.7	78.3	0.0
Ileje DC	Ileje District hospital	13.4	86.6	78.7	107.3	129.8	0.0
	Ngulugulu	21.2	78.8	0.0	99.3	97.3	0.0
	Ngulugulu	2.8	30.6	0.0	5.7	36.7	0.0

Note: Information for the empty cells was not obtained.

8. ANNEXES

8.1 Annex 1: List of documents reviewed

	Authorship	Year	Name of document	Source
1	URT	2016a	MoU between the Government of Tanzania and Development Partners contributing to the Health Basket Fund in support of achieving results related to strategic outcomes and targets of the fifth health sector strategic plan (HSSP V). July 1, 2021 - June 30, 2026	GoT
2	URT	2023b	United Republic of Tanzania. National Health Accounts for Financial Years 2020/21 & 2021/22.	GoT
3	URT	2021b	Health Sector Strategic Plan July 2021 – June 2026 (HSSP V) Leaving No One Behind	GoT
4	URT	2007a	National Health Policy	GoT
5	URT	2021a	Medical Stores Department Medium Term Strategic Plan (MTSP III) (2021-2026)	GoT
6	MoH	2020	Comprehensive Council Health Planning Guideline (CCHP), 5 th Edition.	GoT
7	URT	2021c	Side Agreement Between the Government of The United Republic of Tanzania and Health Basket Fund Partners, Fiscal Year 2021/22	GoT
8	URT	2022b	Side Agreement Between the Government of The United Republic of Tanzania and Health Basket Fund Partners, Fiscal Year 2022/23	GoT
9	URT	2023g	Side Agreement Between the Government of The United Republic of Tanzania and Health Basket Fund Partners, Fiscal Year 2023/24	GoT
10	URT	2024a	Side Agreement Between the Government of The United Republic of Tanzania and Health Basket Fund Partners, Fiscal Year 2024/25	GoT
11	URT	2023f	Medium Term Expenditure Framework For 2023/2024- 2025/2026	GoT
12	URT	2021d	Independent Verification of Health Service Results Supported by the Health Basket Fund and the Strengthening of Primary Health Care for Results Pro	GoT
13	URT	2023a	Universal Health Insurance Act	GoT
14	URT	2022c	Tanzania Demographic and Health Survey and Malaria Indicator Survey 2022 Key Indicators Report	GoT
15	MoH	2024	Tanzania Service Availability and Readiness Assessment (SARA) Report 2023, Dodoma, Tanzania	GoT
16	URT	2023d	Human Resource for Health Tanzania Mainland Country Profile 2023	GoT
17	URT	2023e	Report on Monitoring the Use of Health Basket Fund Funds in Local Government Authorities. Dodoma, Tanzania	GoT
18	URT	2023c	Report of the 23rd Joint Annual Health Sector Technical Review Meeting	GoT
19	URT	2019a	Mid-Term Review Of The Health Basket Fund Functionality At All Levels July 2015 To June 2019	GoT
20	URT	2021e	National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition	GoT

21	MoHCDGEC	2021	National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (2021/2022 - 2025/2026),	
22	Mtenga *et al.,*	2025	Mid-Term Review (MTR) of the Health Sector Strategic Plan V (HSSP V), RMNCAH-N Report.	GoT
23	Ruhago et al	2023	Understanding the implication of direct health facility financing on health commodities availability in Tanzania	Publication
24	Mtei et al	2023	Primary health-care financing and resource mobilization. In Primary health Care in Tanzania through a health systems Lens: a history of the struggle for universal health coverage	Publication
25	Maiba et al	2023	Assessment of strategic healthcare purchasing and financial autonomy in Tanzania: the case of results-based financing and health basket fund.	Publication
26	Mæstad	2021	Direct Financing of Health Facilities. Experiences from financing reforms in Tanzania.	Publication
27	Kapologwe et al	2019	Understanding the implementation of Direct Health Facility Financing and its effect on health system performance in Tanzania	Publication
28	Piatti-Fünfkirchen and Ally	2020	Tanzania Health Sector Public Expenditure Review 2020	Publication
29	Mathias et al	2024	Factors Affecting the Availability of Essential Health Commodities in Tanzania with a Special Focus on the Tracer Commodities.	Publication
30	Binyaruka et al	2024	Does Provider Autonomy Work Well in Tanzania? Perspectives of Primary Care Facilities on Budget Execution under Direct Facility Financing and Factors Affecting Provider Autonomy in Singida Region.	Publication
31	Binyaruka et al	2024	Assessing equity and efficiency of health financing towards universal health coverage between regions in Tanzania.	Publication

Note: GoT– government of Tanzania

8.2 Annex 2: DHIS2 - HBF Indicators

RMNCAH (ANC)	National & LGA	Percentage of pregnant mothers attending first ANC visit (< 20 years)
RMNCAH (ANC)	National & LGA	Percentage of pregnant mothers attending first ANC visit (> 20 years)
RMNCAH (ANC)	National & LGA	Percentage of pregnancy mothers at least attended at least 4 visits.
RMNCAH (ANC) & MALARIA	National & LGA	Proportion of mothers who received 2 doses of intermittent preventive treatment (IPT2) for malaria during last pregnancy during ANC attendance.
RMNCAH (ANC) & NUTRITION	National & LGA	Percent of ANC attendees receiving adequate quantity of Iron and Folate tablets until the next ANC visit
RMNCAH (Labour & Delivery)	National & LGA	Percentage of institutional deliveries coverage
RMNCAH (Family Planning)	National & LGA	Percentage of women of reproductive age (15-49 years) using modern family planning methods, example of family planning
RMNCAH(Newborn) & NUTRITION	National & LGA	Proportion of children breastfed within one hour of birth
RMNCAH (Newborn) & NUTRITION	National & LGA	Percentage of newborn who received postnatal care within two days of birth.
NUTRITION (Micronutrient supplementation, Stunting)	National & LGA	% anaemia in pregnant women attending the 1st ANC visit.
		Percentage of pregnant women with severe anemia
COMMUNICABLE DISEASE (TB)	National and LGA	Number of TB Cases notified
		TB cases notification rate
COMMUNICABLE DISEASE (HIV)	National and LGA	Percentage of people living with HIV are aware of their status
NON-COMMUNICABLE DISEASE	National and LGA	% of Hypertension among in OPD
Gender	National and LGA	Percentage of GBV and VAC survivors who have experienced any violence reporting within 72 hours after the incident
Health System Outputs for Improving Conditions for Quality of Care		
QUALITY	National	Percent of PHC facilities with “3 stars” rating or higher
HRH	National	Percentage of dispensaries that have their required staff (nurse/midwife and clinician)
Health Commodities	National & LGA	Percentage of availability of 30 tracer items (medicines, vaccines, medical devices) in the past year

Governance	National & LGA	Percentage of HFs with functional Health Facility Governing Committees
Information System	Regional (RHMT)	Quarterly data quality audits (DQA) for LGAs conducted according to national DQA standards
ICT	National & LGA	Percentage of Public health facilities with electronic medical records (EMR) for service delivery, tracking health commodities usage and health facility finances
Supervision -RHMT	Regional (RHMT)	Percentage of RHMT's conducted annual supportive supervision visits for LGAs that meets national supervision standards
Supervision -CHMT	Council (CHMT)	Percentage of CHMT's conducted annual supportive supervision visits for LGAs that meets national supervision standards
Finance Management	Council (CHMT)	Percentage of LGAs with unqualified opinion in the external audit report

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