AN ASSESSMENT OF THE CONTRIBUTION OF FOREIGN BUDGET SUPPORT TOWARDS NATIONAL HEALTH GOALS ACHIEVEMENT IN KINONDONI MUNICIPAL COUNCIL

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2019

CERTIFICATION

The undersigned certify that she has read and hereby recommends for the acceptance by the Open University of Tanzania a dissertation entitled õ***An Assessment Of The Contribution Of Foreign Budget Support Towards National Health Goals Achievement In Kinondoni Municipal Counci***lö in partial fulfillment of the requirements for award of the Master Degree on International Cooperation and Development of the Open University of Tanzania.

í í í í í í í í í í í ..í í .
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Date

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DECLARATION

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í í í í í í í í í í í í í í í ..

Signature

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Date

DEDICATION

I dedicate this work to my family particulalrlymy children for their love and encouragement during the whole time of pursuing my masterøs degree. May the almighty God grant them serenity to love more than they did to me, to accept the things they cannot change, courage to change the things they can and wisdom to know the difference.

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ABSTRACT

The study aimed at assessing the contribution of foreign budgetary support on health goals achievement in Kinondoni Municipal council.The study was guided by three research objectives and three research questions. The study used the population from Kinondoni Municipal. The study had a sample size of 27 respondents. The study used purposive sampling techniques in obtaining the sample size. Data was collected through questionnaires and documentary review.The researcher usedboth qualitative and quantitative data in data presentation. The findings shows that thereare different projects which have been funded by donor countries to the budget support in Tanzania. The findings shows that in health sector the selected five projects were fully funded by the development partners ,these projects are DANIDA program, the National Malaria Control Programme, Global Fund Round Eight Project, National Tuberculosis and Leprosy programme, Global Fund Round Three and Six, Global Fund- Tanzania Commission for AIDS, and Health Systems Strengthening Global Funds Round Nine.one of the main challenges which hinder effective budget support is delay of funds from the donors. It has been found that in almost every project there been a delay of funds which leads to failure of accomplishment of projects also in most projects the amount received is less that what has been approved in the budget or what has been agreed to be disbursed.The government is advised to ensure that conditions given by donors as agreed are fulfilled. These conditions are (a) Good governance (b) Adjustments of the country economic policies (c)The money given to be used as agreed (d)Rule of law /Democracy (e) action taken on ESCROWscam(f)Submission of General Budget Support Annual Report.

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LIST OF ABBREVIATIONS

CAG	Controller and Auditor General
DANIDA	Danish International Development Agency
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
ICT	Information Communication Technol
LLINs	Long Lasting Insecticide Nets
MoEVT	Ministry of Education and Vocational Training
MOHSW	Ministry of Health and Social Welfare
NACP	National Aids Control Program
SEDP	Secondary Education Development Program
TNCM	Tanzania National Coordinating Mechanism

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Introduction

This chapter presents the general introduction of the study. The chapter presents background of the study, statement of the problem, objective and research questions, scope of the study as well as rationale of the study.

1.2 Background Information

Over the past decade, significant efforts have been made by developing countries to improve the life of their population. The world attained the first Millennium Development Goal target to cut the 1990 poverty rate in half by 2015- five years ahead of schedule in 2010 (World Bank, 2015).However, according to the estimates, seventeen percent of the population living in developing countries lived below $ 1.25 a day. This means that although progress in alleviating poverty has been made, considerable actions still need to be implemented by developing countries; to end extreme poverty within a generation and promote shared prosperity in a sustainable manner across their countries (Global Monitoring Report, 2014).

According to the Department for International Development (DFID), economic growth is the most powerful instrument for reducing poverty and improving the quality of life in developing countries. From a macroeconomic perspective, it is measured by the growth in Gross Domestic Product (GDP). The growth in GDP is a function of total productivity, capital and labor produced by the economy of a country (DFID, 2015). The literature about foreign aid covers many features of aid

ranging from aid volatility(Bluer &Hamann,2008; Arellano,Bulir,Lane &Lipschitz,2009; Pallage&Robe,2001; Eider & Gelb,2005; Hudson,2015); aid fungibility (Jones,2005; Hadjiyiannis, Hatzipanayotou& Michael,2013; Devaranjan& Swoop, 1998; Hangmen, 2006); aid absorption (Martins,2011; Hussein, Berg&Aiyar,2009) to aid effectiveness in relation to growth (Rajag& Subramanian,2008; Arndt, Jones &Tarp,2010; Mosley, Hudson & Horell,1987; Arndt, Jones &Tarp,2015).

Developing countries rely on aid to support their balance of payment, to provide additional funding to compensate their fiscal deficits, to invest in massive infrastructure projects, to obtain technical assistance, to relieve the country from debts. For country affected by war and natural disasters; foreign aid is welcomed in the form of food aid, peacemaking effort and emergency aid (Bulir and Hamann, 2003). In the case of Tanzania, the country has been receiving increasing amount of foreign aid in past decades. Nyoni (2013) noted that since the 1980s, the local government in Kinondonihas been engaged in a series of economic reforms among which: The National economic survival program in 1981, the structural adjustment program in 1982, the economic recovery program I and II in 1986 and 1989.

Coupled with the relatively stable political condition of the country, these reforms attracted the donor communityø attention, especially the International Monetary Fund and the World Bank. Concomitant with the implementation of the reforms, the Tanzanian Government continues to receive large amount of aid making the country to be heavily aid dependent. In 2010/2012 financial budget, foreign aid made up a total of 28.2% of the total budget.

According to the annual general report of the controller and auditor general on the financial statements for the year ended 30th June, 2017 for central government, sources of funds to finance government budget has remained the same with little variations while the government budget has been increasing yearly. Main sources of Government finances include tax, non tax, general budget support, internal borrowings, external borrowing and assistance. The approved budget has increased from 18,248.98 billion in the year 2013/14 to TZS 19,853.3 billion in the year 2014/2015 representing an increase of approximately 8.8 per cent.

Actual External Borrowing, Assistance and General Budget Support received during the Financial Year 2014/15 was TZS 3,601.95 billion (84.5%) against approved estimates of TZS 4,261.60 billion which means external assistance amounting to TZS 659.65 billion (15.47%) was not received. Despite of the foreign budget support to Kinondoni, its yet known how far has the national goals in the health sector being attained in the country therefore this study intends to find out the contribution of budgetary foreign aid on achieving national goals in the health sector in Tanzania.

1.3 Statement of the problem

Kinondoni municipal council ` has been receiving considerable amountsof financial assistance from different countries in the world for many years to support thehealth sector system in the country. Different studies have shown that Kinondoni hasbeen receiving a considerable amount of budgetary support from different countries such as from England, China, United stated of America andfrom Scandinavian

countries (Gao, 2012, Richardson , 2013, Sangao, 2014 and Ngowi, 2015).However the studies have been contradictory or inconclusive on the contribution of foreign budget support on improving the health sector system, hence the budget support have been coming with a number of recommendations to fulfill which in turn favor the donors but not KinondoniMunicipal Council (Ntulilwa,2014).

However some studies have shown that there is no any significant contribution of the foreign budget support in the health system in the country hence most of the support do come very late and less as promised, as the result most of the targeted goals cannot be reached extensively in the health system, it is believed that most of the foreign budget support granted to Kinondoni health system are not directed to the areas of interest as the result no significant achievement is attained on the health system in the country(Johnson, 2013).

Contrary to Gisabu,(2014) who argues that most of African development have been reached due to budgetary foreign aid hence most of the African nations can hardly support their budget by 20% to 30% only. Therefore, national developments cannot be reached by such high budget deficient. As stated above, the studies are inconclusive or contradictory on the exact contribution of foreign budgetary support of the achievement of national health system development. Therefore, this study assessed the exact contribution of the foreign budgetary support on the health development achievement in Tanzania.

1.4 Main Objective of the Study

To assess the contributionof foreign budgetary support on health goals achievement

in Kinondoni Municipal council.

1.4.1 Specific Objective

(i) To assess the effectiveness of budget support in preventing H.I.V/AIDS and other diseases.

(ii) To findout the extent to which health facilities are accessible to people

(iii) To assess impact of capacity building resulting from budget support in terms of improvement of health services.

1.5 Research Questions

1.5.1 Main Research Question

What is the contribution of foreign budgetary support on health goals achievement in Kinondoni Municipal council.

1.5.2 Specific Research Questions

(i) How effective is foreign budget supportin preventingH.I.V/AIDSand other diseases?

(ii) Has the accessibility of health facilities improved as a result of foreign budget support?

(iii) How effective is foreign budget support in capacity building of the healthpersonnel?

1.6 Significance of the Study

The study broadens the understanding of foreign budget support and its impact on the achievement of health system goals in Tanzania. Furthermore, the study helps to

know what initiatives have been taken in Kinondoni to ensure that the national health goals are being achieved and there is full utilization of foreign budget support. The study provides an alarming note on the weaknesses in the existing policies and laws and hence a call for review and amendment on the use of foreign budgetary support in the country. It also provides a picture to high level authorities and responsible entities on how to mobilize effective utilization of foreign aid in the country.

1.7 Scope of the Study

This study was limited to the geographical boundaries of Kinondoni Municipal Council. The study focused on assessing the contribution of foreign budgetary aid on health goals achievement in Kinondoni particularly. The study was specifically looking at health service goals achieved and the challenges hindering effective foreign budgetary aid management in Kinondoni

1.8 Organization of the Study

This study has five chapters. The first chapter is on the general introduction of the study, it presented the background information of the study, statement of the problem, specific objectives, research questions, rationale of the study, and scope of the study. Chapter two has presented the review of related literature, whereas it has presented the definition of key terms, theories, theoretical argument, empirical analysis, research gap and conceptual framework.

The third chapter to this study was research methodology; the chapter presented the research design, area of the study, population of the study, sample size and sampling techniques, tools of data collection as well as data analysis and presentation. The

fourth chapter presented the findings of the study and their interpretation and last chapter was chapter six which presented summary of the study, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the reviewed textual material, empirical literature reviews, theoretical frame related to the research topic to present ideas and concepts on the research variables of the topic under study, which will highlight what has been done and what has not yet been done in relation to this study. The literature reviewed has addressed the research objectives and question as studied by other researchers. At the end, the gap has been identified.

2.2 Theoretical Argument

2.2.1 The Concept of National Goals

A goal is a desired result or possible outcome that a person or a system envisions, plans and commits to achieve: a personal or organizational desired end-point in some sort of assumed development. Many people endeavor to reach goals within a finite time by setting deadlines. It is roughly similar to purpose or aim, the anticipated result which guides reaction, or an end, which is an object, either a physical object or an abstract object, that has intrinsic value. National goals are goals set by the President during the presidential elections. Goals are in three categories, social, economy, and military. (Kageyo, 2013)

2.2.2 The Concept of General Foreign Budget Support

Budget support is a particular way of giving international development aid, also known as an aid instrument or aid modality. With budget support, money is given

directly to a recipient country government, usually from a donor government. Budget support differs from other types of aid modalities such as: Balance of payments support, which is currently mainly the domain of the International Monetary Fund. With balance of payments support the funds go to the central bank for foreign exchange purposes, while with budget support they generally go to the Ministry of Finance (or equivalent) and into the budget for public spending. Project aid, are aids where development assistance funds are used by donors to implement a specific project, with donors retaining control of the project's financing and management(Jones, 2005).

In practice, budget support varies dramatically and is done in a large range of different ways. One of the broadest distinctions is between general budget support and sector budget support. General budget support is unearmarked contributions to the government budget including funding to support the implementation of macroeconomic reforms (structural adjustment programs, poverty reduction strategies)(Kolawole,2013).

Budget support is a method of financing a recipient countryøs budget through a transfer of resources from an external financing agency to the recipient governmentøs national treasury. The funds thus transferred are managed in accordance with the recipientøs budgetary procedures.Funds transferred to the national treasury for financing programs or projects managed according to different budgetary procedures from those of the recipient country, with the intention of earmarking the resources for specific uses, are therefore excluded. Sector budget support, like general budget support, is an un earmarked financial contribution to a recipient governmentøs

budget. However, in sector budget support, the dialogue between donors and partner governments focuses on sector-specific concerns, rather than on overall policy and budget priorities(Kolawole, 2013).

2.2.3 Characteristics of Foreign Budget Support in the Health Sector

2.2.3.1 General Budget Support as Aid-Modality

Roughly speaking, aid modalities can be divided into project aid and program aid. Project aid targets a specific issue of certain sector/sub-sector with clearly defined period of time and objectives for its implementation. Program aid addresses a sector or macro-level development issues, based on agreed-upon national development strategies between recipient countries and donors. Programme aid can be further divided into food and financial programme aid, and the latter further can be classified into balance of payments assistance and budget assistance. GBS belongs to the budget assistance category (Okio, 2013).

2.2.3.2 Fungibility in the Health Sector Budget

According to Chiza (2012), fungibility refers to a situation in which donorsø aid money changes the budget constraint of the recipient country, causing part of the aid to be expended for unintended purposes.

In discussing characteristics of GBS that provides funds to the recipient countryøs general budget, fungibility is an important issue. Since fungibility is often regarded as one of the possible factors for an inefficient allocation of funds, discussions on fungibility are frequently focused on how to limit it. In GBS, however, a recipient country is expected to manage all aspects of resources for national development

strategies (both domestic revenues and donorsø aid money) through public financial management and mid-term expenditure frameworks. Therefore, GBS can be regarded as an aid modality, which could effectively control the problem of fungibility.

2.2.4 Aims and Activities of General Foreign Budget Support

2.2.4.1 Ownership of Recipient Countries

Foreign budget support would require recipient countries to fulfill certain conditionalities. Such conditionalities are decided through policy discussions between recipient countries and donors, based upon recipient countriesø national development strategies, such as Poverty Reduction Strategies (PRS). Since GBS funds are directly put into the general budget of recipient countries, specific allocation of funds is to be at recipient countriesø discretion, utilizing their budgetary, accounting, and administrative systems/institutions. Therefore, itbecomes easier for recipient countries to establish their own development strategies. In this way, it can be said that GBS is likely to strengthen the ownership of recipient countries (Gao, 2013).

2.2.4.2 Governance of Recipient Countries

Foreign budget support funds are distributed through the budget and accounting system of recipient countries. In addition to provision of funds, donors provide support through policy dialogue and technical assistance to recipient countries when recipient countries decide development strategies and budget allocations. Such inputs provided by donors would enable recipient countries to strengthen their budgetary and administrative capacities as donors utilize and rely on recipient

countriesø budgetarysystems/institutions of the disbursement of their funds (Rwegoshora,2006).

2.2.4.3 Transaction Costs of Aid

Foreign budget support is an aid modality with which donors could coordinate and harmonize their aid activities under the ownership of recipient countries. With aid activities more harmonized, the workload for recipient countries is expected to be lessened, thereby reducing transaction costs of aid, in contrast to the situation where each donor carries out their assistance and evaluations separately (Smyth, 2012).

2.2.4.4 Predictability of Aid

Since foreign budget support modality frequently entails medium-term financial commitments by donors, there is likely to be less fluctuation on an expected amount of aid, thus increasing aid predictability for recipient countries. Increased predictability is expected to have a good impact on macroeconomic management. Twenty percent of the government expenditure in Kinondoniøs funded through GBS (as of 2004). Therefore, a predictable amount of GBS will enable the recipient country to plan ahead on budgeting, economic management, and implementation of development strategies (Rutann, 2012).

2.2.4.5 Domestic Accountability

Foreign Budget Support is expected to enhance domestic accountability, as well as budgetary and administrative reforms in public expenditure management and auditing. Under improved public expenditure management and auditing, an

allocation of funds will be guided by national development strategies toward prioritized sectors (Rolfstan, 2012).

2.2.5 The Health Sector and General Budget Support

The early participation of health sector decision-makers in the Poverty Reduction Strategy (PRS) process, the prelude to budget support, can contribute to the identification of priorities in health and encourage the Ministry of Finance to release the additional financial resources to respond to those. This will also enable the identification of realistic benchmarks of reforms for policy conditions or performance indicators of budget support programs. Most importantly, it will ensure shared accountability on selected benchmarks between core ministries, ministries of health and development partners (Richardson, 2013).

In the case of SBS for health, earmarking resources could be seen to impose additional responsibilities on ministries of health: Taking the lead from policy-dialogue required during the design and implementation of the programme; collecting information and evidence required for the development of national plans; and assuming shared responsibility for the use of resources and delivery of results. However, these are fundamental responsibilities of any ministry and are essential not only for the success of SBS or GBS programmes but also for the daily activities of the ministry (GoT, 2010).

2.2.5.1 Additional Budget Resources for Health

The multi-donor GBS has made substantial resources available to the discretion of the government for its pro-poor policies. The Ministry of Health has acquired

through its engagement in budget support program, valuable experience and is strongly engaged in subsequent budget negotiations and priority setting. As a result, health sector priorities are reflected in the national budget and its resources have enabled the removal of user fees in public facilities, in an effort to improve access to services towards universal coverage (Ndunguru, 2013).

Forms of budget support and debt relief often make substantial additional resources available for national budgets but the fiscal reforms that accompany them sometimes pose an additional burden for the poor. A way to mitigate this burden is to ensure that some of the additional resources are allocated specifically to improve the health of the poor. Indeed, when Ministries of Health negotiate with Ministries of Finance for their share of additional budget support, they should use the argument that improving health in an important way of improving the lives of people, including their economic productivity. This requires the early and active engagement of Ministries of Health in GBS negotiations (Oscar, 2012).

2.2.7 Challenges Facing Management of General Budget Support

Many of them result from the conscious efforts of donors and governments to include discussion of certain key topics in the policy dialogue. Others, such as the enhanced predictability of aid disbursements, may present greater challenges to those involved, and thus require stronger efforts, as a result of the choice to use general budget support over other aid instruments (Theredore, 2012). Still others, such as strengthening democratic accountability, are unlikely to result at all and may in fact be endangered as a result of the decision to use general budget support, depending on

the context in which it is provided.

Finally, reduced transaction costs as commonly depicted, may not be desirable aims of general budget support in the first place. In my view, what one can reasonably expect general budget support to achieve ó and even what one might want it to achieve ó needs to be reconsidered.

There is no doubt that a role for general budget support exists, but it is also clear that it misses a great deal and will require complementary investments, likely in the form of other aid modalities, to be an effective instrument for poverty reduction. While most donors in Kinondonirecognize this, it is difficult to avoid the impression that these same donors continue to believe that budget support is a õpreferredö or more õprogressiveö aid instrument (Kambo, 2012).

2.2.7.1 Demand for Services

Perhaps the clearest advantage of general budget support over other aid modalities is that it does not hinder the accountability relationships that should exist between budget allocation authorities and authorities to which public resources are allocated. By limiting access to extra budgetary finance, assistance in the form of general budget support reinforces budget discipline within a recipient government, and this appears to be happening in Kinondoniwith greater shares of assistance provided as general budget support. But effective service delivery, one of the ultimate aims of general budget support, requires that a web of accountability relationships be strengthened ó not simply those within a recipient government(Mbah and Amassoma, 2014). .

General budget support reinforces what Pritchett and Woolcock (2014) call the õneeds/supply/civil serviceö response to the observed absence of key services in developing countries. That is, õneedö is the problem, õsupplyö is the solution, and the õcivil serviceö is the vehicle for implementation. Unfortunately, as the authors note, this approach to service delivery has proven õso seductive to governments (and donors) alike that it has taken decades of painful and expensive failures in sector after sector to see that the problem is not just a few mistakes here and there, but that as an approach to development, it can be fundamentally wrong-headed from top to bottomö. These failures, they argue, are the direct consequence of õthe lack of feedback mechanisms and modes for engagement of citizens in either controlling the state or directly controlling providersö

Pritchettøs and Woolcockøs (2014) point of departure is to distinguish between the levels of discretion and õtransaction intensivenessö involved in public sector activities. Discretion refers to the extent to which an activity requires extensive professional or context-specific knowledge i.e., judgment. Transaction intensiveness refers to the number of transactions required to undertake an activity. The authors refer to activities that are discretionary but not transaction intensive as õpoliciesö ó e.g., lowering tariffs. Activities that involve many transactions but require relatively little discretion, and therefore can be mechanized to a large degree, are õprogramsö ó e.g., administering vaccinations.

However, many services that ultimately affect outcomes and contribute to poverty reduction ó classroom teaching, curative health care, allocation of water flows, etc. ó are discretionary and transaction-intensive, what the authors,

define as practices and their successful delivery is extremely difficult to replicate.

> *The provision of key, discretionary, transaction-intensive services through the public sector is the mother of all institutional and organizational design problems ... Multiple levels of interaction must be addressed simultaneously: between citizens and the government, between government and agencies, between agencies and its employees/contractors (the providers), and between citizens and providers, and public authorities" (Pritchett and Woolcock,2014)*

While general budget support may have a positive effect on the relationships betweengovernment and agencies and, perhaps more optimistically, the relationships between agencies and its employees/contractors, it cannot reasonably be expected to improve the relationships between citizens and government and between citizens and providers.

Pritchett and Woolcock (2014) catalogue eight alternatives to the failed õneed/supply/civil serviceö approach to service delivery that have been tried in recent years. They are careful to note that each approach has advantages and disadvantages ó none is inherently õbetterö than the others. But all of the approaches endeavor to enhance the responsiveness of service delivery to citizen preferences. In other words, they seek to address the õdemand sideö of service delivery. A recent survey on citizen satisfaction with service delivery in PRS priority sectors in Kinondonirevealed that a vast majority of Tanzanians are dissatisfied with the quality of the services available to them (REPOA 2013).

Sundet (2013) suggests that the key reason for the surveyøs findings is that

Tanzanians are not sufficiently empowered to hold their Government and service providers accountable. What then can donors do? According to Kaufmann (2013),

> *"focusing more on parliamentary, NGO, and citizen oversight is crucial, as is the transparent use of new tools such as citizen scorecards; diagnostics based on survey reports from public officials, public-service users, and firms; and tools to track public expenditures in detail ... Where it has not been captured by monopolistic state's or elite's vested interests, the media can play a key role in pro-transparency governance reforms."*

2.2.7.2 Capacity Building

A second advantage of general budget support over other aid modalities is that it is more effectively draws on governmentsø existing budgeting and planning capacities and can have the effect of strengthening those capacities as a result of learning-by-doing effects. But in Kinondoni it is widely recognized that most actors ó the Parliament, NGOs, the private sector, research organizations, the media, etc. ó suffer from serious capacity constraints.

As has been argued, the effectiveness of service delivery will depend to a great extent on these actors being able to play their appropriate roles in holding the Government accountable, disseminating accurate information to citizens, engaging in informed policy debate, and contributing to a growing economy that helps deliver sustainable benefits to Tanzanians(Kolawole, 2013).

General budget support offers little assistance to these entities for strengthening their capacities. In addition, it is likely that there are limits to the capacity building effects

of general budget support within the Government. For example, general budget support requires that line ministries develop greater technical capacity to more effectively make their cases to the Ministry of Finance for budget allocations since they lose access to extra-budgetary finance. Technical assistance can help in this regard. Even when it comes to improving public expenditure management ó perhaps the most automatic benefit arising from providing assistance as general budget support ó technical assistance is often needed. The point is not that general budget support is an inappropriate instrument for aid delivery, but rather that it requires various forms of complementary investments to deliver the kinds of benefits to which it aspires (Jones, 2005).

2.3 Empirical Review

Ranjan and Subramanian (2008) examined the effect of aid on growth in cross-sectional and panel data analysis (using the GMM estimation method) of 42 developing countries. They found little evidence of a robust positive correlation between aid and growth. They also found that there is little evidence that aids work well in better policies or institutional environments, or that certain kind of aids work better than other. They also found weak (and mixed) evidence that aid works better in some geographical setting.

Boone (2009) tested the prediction for aid effectiveness based on an analytical framework that relates aid effectiveness to political regimes. Using regression analysis, panel data and Instrumental variable techniques the results of his finding were that aid does not significantly increase investments, nor benefit the poor as measured by improvement in human development. He also posited that aid does

increase the size of the government as government consumption does rise by three quarter of the total aid.

Mosley *et al.*,(2012) early confirmed the finding of Boone (2009). Using a modified variation of the Harrod-Domar growth model on 88 developing countries, they found that aid is used to fit governmentsø constraints rather than promoting growth and development in those countries. Early in the literature, Griffin and Enos (2012) using a cross country regression analysis of 27 non African developing countries posited that aid has neither accelerated growth, nor helped to foster democratic political regimes.

They argued that if anything, aid may have retarded development by leading to lower domestic saving, by distorting the composition of investment and thereby raising the capital output ratio, by frustrating the emergence of indigenous entrepreneurial class. In this line therefore, they argued that inflow of aid to developing countries is counterproductive to economic growth.

In the case of Tanzania, Conchesta (2008) using descriptive statistics and regression analysis on the growth rate and aid received by Kinondonifrom 1990 to 2004, found that aid has a negative impact on growth and that both development and recurrent government expenditures on foreign aid also has a negative impact on growth in Tanzania.Burnside and Dollar (2000) introduced the variable aid-policy in the study of aid effectiveness. They used 275 observations in 56 countries from 1970 to 1993 and both the ordinary least square (OLS) and the two stage least square (2SLS) method of estimation. Their result was that aid has a positive impact on growth in,

countries with good fiscal, monetary and trade policies and little effect on grow in the presence of poor policies.

In other words growth can result from foreign aid only if it is conditioned to sound policy being implemented by the recipient countries. The requirement for good policies were early emphasized by Durbarry*et al,* (2008). Using both cross sectional and panel data analysis of 68 aid receiving countries they posited that conditional to good macroeconomic policies, foreign aid has a positive effect on growth. Macroeconomic policies in their analysis meant predictable and low inflation, appropriate real interest rates, competitive and predictable real exchange rate, sustainable fiscal policy and predictable balance of payments (Durbarry*et al* 2008).

However, they saw that there are decreasing return to aid and the estimated effectiveness of aid is highly sensitive to the choice of estimator and the control variables. When investment and human capital are controlled for, they saw that there is no positive effect on aid. Yet they agreed that aid continue to impact on growth via investment.

Juselius*et al,* (2014) used a Cointegrated VAR model as statistical benchmark to study the long run-impact of foreign aid in 36 African countries. They found that aid has a positive long run impact on investment and GDP and that there is little evidence supporting the thesis that aid has been harmful.

Minoiu and Sanjay (2009) examined the impact of foreign aid from 1960 to 2000 in 107 countries. In their analysis, they differentiate between developmental aid (aid expanded in a manner that is anticipated to promote development, whether achieve

through economic growth) and non- development aids (other kind of aid). Using OLS, Panel 10 data and the GMM as estimation techniques, they found that development aid produces longterm growth with the effect being significant, large and robust. While Non- developmental aid is growth-neutral, and occasionally negatively associated with growth. Chong *et al*, (2010) used a 33 years regression analysis from 1970 to 2002 to examine the effect of foreign aid on the economic growth of Tanzania. They found that foreign aid work effectively unconditionally and that the addition of good policy would foster the growth. Arndt and Jones (2015: 9) in their own classified countries based on whether they were Colonies of a given donor from 1960 to 2007. With a sample of 78 countries, they posited that there is no evidence that nearly 40 years of development assistance has had an overall detrimental effect on development outcome.

2.4 Conceptual Framework

Independent Variables Intermediate Variables Dependent Variable

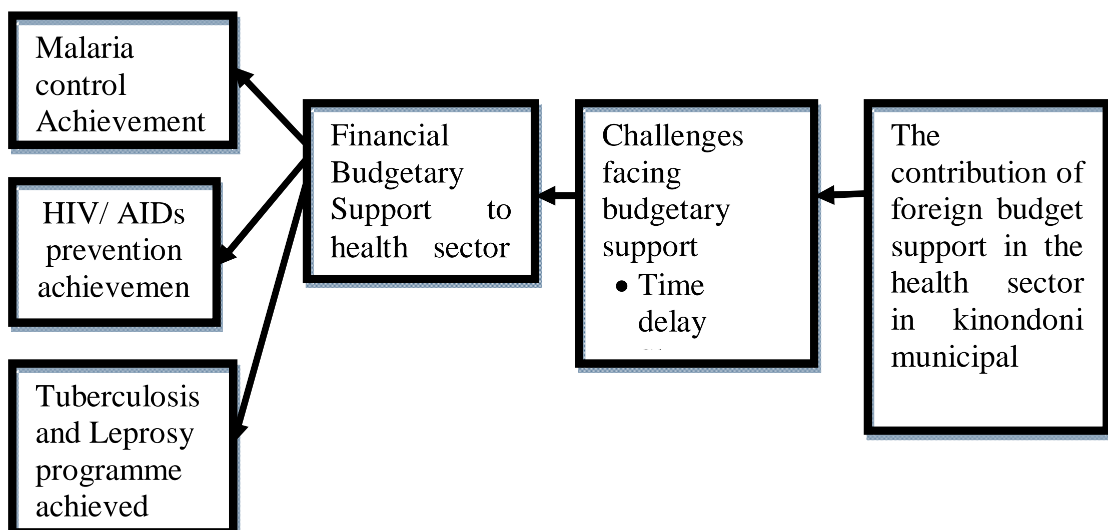

Figure 2. 1: Conceptual Framework

Source: Researcherøs Creation (2018)

The conceptual framework above shows the independent and dependent variables of the study affected each other in the study. The first independent variable to this study was Malaria control Achievement in Kinondoni Municipal. The study looked at Distribution of LLINs to household through mass campaign LLINs issuing through a logistic contractor, training and sensitization of local government officcials to conduct the universal coverage mass distribution campaign, create demand for free distribution of LLINs and raise the profile of malaria through mass media and create demand for free distribution of LLINs and raise the profile of malaria through community outreach.

The second independent variable to thisstudy was HIV/AIDs prevention achievements in Kinondoni Municipal due to foreign budget. The last independent variable to this study was tuberculosis and leprosy achieved. The study looked at: TB/HIVcollaborative activities: Prevention of HIV in TB patients, TB/HIV collaborative activities: Provision of antiretroviral treatment for TB patients during TB treatment, Strengthening NTLP Monitoring and Evaluation System and looked on community TB care (CTBC) Furthermore the there were two intermediate variables whereas the researchered looked on the financial budget which were offered to the municipal, furthermore the researcher looked on the possibles challenge facing the budgetary support such as time delay and shortage of the amount offered as agreed. The dependent variable to this study was the contribution of foreign budgetary support to the goals attainment in Kinondoni Municipal

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the description of the methods applied in carrying out the study. It is also organized under the following sub-topics:- area of study, research design, population under study, sample size and sampling technique, data collection and analysis.

3.2 Research Design

The research was case study design. Case study design was selected due to the fact that it allows investigation in-depth and with great attention on a particular problem. This approach gave insight into the problem understudy, detailed investigation enabled the researcher to know more about the contribution of budgetary foreign support of national goals achievement particularly in the health sector. Using this design the researcher was able to obtain exclusive data on the problem being studied as it gave a room for intensive interviews which enabled the problem to be well understood.

3.3 Study Population

The population for this study was employees from KinondoniMunicipal Council who take part in the planning, design and implementation of the municipal budget. The group of people making up this population includes the employees from Kinondoni Municipal council. Population of the study is described as the entire group of people or item on which information is collected. Population of the study

originated from employees of the municipal ; the number of people interviewed was determined by the role of the part concerned in the municipal. Bearing in mind that the study cannot take the whole population as unit of analysis; hence this research took only the required sample size from the targeted population.

3.4 Sample Size and Sampling Techniques

3.4.1 Sample Size

According to Kothari (2006), a sample size of the study should neither be excessively large nor too small. An optimum sample is the one which will fulfill the efficiency, representative, and reliability and flexibility requirements. The sample size determined was based on the criteria such as the required level of precision in the results and the level of detail of the analysis. The respondents were selected for estimation of the results of this which depended on the parameter being estimated, the variation of the estimator, and the distribution of the statistics was used to create the standardized estimate and its confidence interval. Based on this selection criterion, this study chose a sample size of 27 respondents from a population of 30 targeted size

3.4.2 Sampling Techniques

In order to obtain true representation of the population, a purposive sampling and convenient process was used. Purposive sampling technique refers to the sampling techniques which enable a researcher to select a sample based on his /her knowledge of population, research elements and objectives. Purposive sampling is also based on researcherøs judgment and purpose of the study, Kothari (2006). Basing on this

technique, the researcher selected 27 respondents out of 30 sample size from Kinondoni Municipal Council who are aware of the budgetary foreign support.

3.5 Data Collection Methods

In conducting this study; both primary and secondary data collection techniques were adopted. Data means information which helps researcher to achieve research objectives. The quality of research largely depends on collected information and more reliable data leads to more dependable research. This is dependent on data collection method that researcher selected to achieve the objectives and the data helped the researcher in decision making. Primary data was obtained through interview.

Secondary data are data which are not collected or gathered by researcher himself or herself. This type of data was previously collected by someone else for some other purpose (Hodges &Videto , 2005). There are two benefits of this data collection method. This method is less expensive and less time consuming. Through this method, data can be obtained easily and quickly. These data were collected by third party for their own purposes. Books, Government sources, Regional Publications, commercial sources, media sources and selected internet sites that provide procurement data are some example of secondary data sources.

3.5.1 Interview

This is the verbal face-to-face conversation between the researcher and respondents in the study area. There are three forms of interviews namely, structured, semi-structured, and unstructured (Fontana &Frey, 2005). In this study, both structured

and semi structured interviews were used. The structured interview mainly involved closeended questions to solicit demographic information from the respondents and inviting free and open discussion. The semi- structured interview was used to collect information from monitoring and evaluation of the national budget. The interviewees was guided by the already prepared interview guide.

3.6 Validity and Reliability Issues

Joppe (2000), defines reliability as the extent to which results are regular over time and an accurate representation of the total population under the study. If the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. It refers to whether the result is replicable. Validity refers to universal laws, evidence, objectivity, truth, actuality, deduction, reason, facts and mathematical data to name just a few (Winter, 2000).Validity determines whether the research truly measures that which was intended to measure or how truthful the research results are. It refers to whether the means of measurement are accurate and whether they are actually measuring what they are intended to measure.

The tools designed for collecting data were proof read and pre tested so as to unveil the validity in terms of the data they give or measure truly and understand the reliability in terms of how the responses are consistent from one person to another. To test validity and reliability of methods for data collection and analysis, a pilot study was conducted two months before the actual data collection. This was done in order to observe the following: Test data collection instruments, see if tools allow collection of required information, and hence identify potential problems, assess and

estimate the time needed for data collection, check availability of study population and reactions of respondents and test procedures for data processing and analysis. Corrections were based on the experience from the respondents during pre testing.

3.7 Data Analysis

Data analysis means the computation of some indices or measures along with searching for patterns of relationships that exist among the data groups.Analysis, particularly in the case of survey or experimental data, involves estimating the values of unknown parameters of the population and testing hypotheses for drawing inferences (Kothari, 1990). According to Kothari, data analysis takes place after data have been collected. Analysis of data requires a number of closely related operations such as estimation of categories, application of these categories to raw data through coding, tabulation and then drawing statistical inferences.

Collected data was condensed in few manageable groups and tables for further analysis. Thus, the researcher classified the raw data into some purposely and usable categories. Tabulation was part of a technical procedure where classified data was put into tables. The analysis was based on the computation of various percentages and coefficients by applying various well defined statistical formulae (SPSS). In the process of analysis relationships or differences supporting or conflicting with the original were subject to tests of significance to determine their validity.

CHAPTER FOUR

PRESENTATION OF RESULTS AND ANALYSIS

4.1 Introduction

This chapter summarizes the statistical results, general observations and outcome of data analysis. The methods employed were both quantitative and qualitative in nature. Therefore data were analyzed by using factor analysis. The study had three. The findings. The findings are presented in thematically order while refering to the study objectives

4.1.1 Demographic and Social Economic Characteristics of the Respondents

The researcher expected that 30 respondents would participate in this research study. However, during the execution of the study only 27 respondents returned the dully filled questionnaires. Therefore the response rate was 90 percent, which is considered as very satisfactory and wants further analysis.

4.1.2 Sex of Respondents

The respondents were asked to indicate their sex. Table 4.1 presents the findings.

Table 4. 1: Distribution of Respondents by Sex

Category	Frequency	Percentage
Female	16	59
Male	11	41
Total	27	100

Source: Research Findings, 2018

Table 4.1 shows that 59% of the respondents were females while 41% were males. This implies that more females participated in this study than males. By including both sexes the researcher expected to increase the validity of the results since both males and females are involved in the managerial operations of the Kinondoni Municipal

4.1.3 Marital Status of Respondents

As part of demographic characteristics, analysis was made to determine marital status of the respondents . The findings are presented in the table 4.2.

Table 4. 2: Distribution of Respondents by Marital Status

Category	Frequency	Percentage
Married	13	48
Single	5	19
Divorced	3	11
Widow/widower	6	22
Total	27	100

Source: Research Findings, 2018

Table 4.2 shows that 48% of the respondents were married, 19% were single, 11% were divorced and 22% were widows or widowers.

4.1.4 Academic Qualifications of the Respondents

The researcher also wanted to find out the academic qualifications of the respondents of the study area. The analysis of respondentsø academic qualifications is presented in the table 4.3. The table 4.3shows that 30% of the respondents were certificate

holders, 11% were diploma holders, 33% were first degree holders, while 19% were masters holders and only 7% were PhD holders. This implies that most of the respondents were well educated therefore, they have the needed information to this study.

Table 4. 3: Distribution of Respondents by Level of Education

Education level of the respondents	Frequency	Percentage
Certificate holders	8	30
Diploma holders	3	11
Degree holders	9	33
Masters holders	5	19
PhD holders	2	7
Total	27	100

Source: Research Findings, 2017

4.1.5 Age of Respondents

Age was considered to be one of the factors in the demographic characteristics of the respondents, therefore analysis was done and the findings are presented in the Table 4.4.

Table 4. 4: Distribution of Respondents by Age

Age	Frequency	Percentage
below 25	5	19
between 25 and 35	10	37
between 35 and 45	9	33
above 45	3	11
Total	27	100

Source: Research Findings, 2018

Table 4.4, shows that 19% of the respondents were aged below 25 years, 37% were aged between 25 and 35 years, 33% were aged between 35 and 45 years and 11% were aged above 45 years. This gives an impression that most of the respondents were matured enough.

4.1.6 Working Experience of the Respondents

Knowing for how long respondents had been in management profession was of major concern to the researcher, hence the reason of establishing the level of experience in relation to their knowledge on the management. The findings are presented in the table 4.5.

Table 4.5: Distribution of Respondents by Working Experience

Experience	Frequency	Percentage
below 5 years	5	18
between 5 and 15	8	30
between 15 and 20	10	37
above 25	4	15
Total	27	100

Source: Researcher Findings, 2018

Table 4.5, shows that 18% of the respondents had a working experience of below five years, 30% had an experience of between 5 to15 years, while 37% had an experience of 15 to 20 years and only 15% had an experience of between 25 years. This gives an impression that most of the respondents had enough working experience.

4.2 The Malaria Control Programein Kinondoni Municipal Council

The first objective to this study was health achievement made on malaria control due to foreign budget support in Kinondoni Municipal. The analysis was done and presented in the subsections below. The findings shows that one of the projects

was National Malaria Control Programme Global Fund Round Eight Project under Grant Agreement TNZ-809-G11-M. The Government of the United Republic of Tanzania (URT) entered into Agreement with the Global Fund to fight AIDS, Tuberculosis and Malaria on 13th May, 2015. The Global Fund will provide funding to the URT to oversee the implementation of the Programme of õPrompt and Effective Treatment of Malaria Cases and Detection and Containment of Malaria Epidemicsö (CAG report for the financial year 2015/2016).

According to CAG report, the main programme objectives are as follows: The programme focuses on distribution of Long Lasting Insecticide Nets (LLINs) to the population as a whole through a further series of mass campaigns to achieve universal LLIN coverage, strengthen malaria infrastructure at the regional level, and Lay the foundation for defining the mechanisms for the sustainable maintenance of universal coverage in the future.The programme is financed by the Global Fund grant to the URT with an amount which will not exceed US$ 20,707,304 (Twenty million Seven hundred and Seven thousand Three hundred and Four United States dollars;i.eEquivalent to TZS 32,386,223,456.00).The National Malaria Control Programmehad the following fund from Global Funds Round Eight activities.

Table 4.6 shows the physical performance of the project were all activities targeted were implemented as per CAG report for the financial years 2010/2011.There was an opening balance of USD 17,880,890.00 (equivalent to TZS. 27,914,016,518.90) when added to the amount received during the financial year 2011/2012 of USD 3,854,187.00 (equivalent to TZS 6,016,805,627.96), the total revenue becomes USD

21,735,077.00 (equivalent to TZS.33,930,822,146.86) the total expenditure as per CAG report was USD 20,477,038 (equivalent to TZS. 31,966,886,267.42).

Malaria has been a major cause of illness and death in Tanzania Mainland and therefore, the disease remains a major impediment to social, economic growth and welfare. To reduce the burden of malaria, the United Republic of Tanzania, has undertaken considerable efforts supported by various stakeholders and partners (national and international) to fight against the disease burden. The National Malaria Control Programme (NMCP) implements the current national Malaria Medium Term Strategic Plan, covering the period between 2008 and 2013.

The goal is to significantly reduce morbidity and mortality due to malaria to a level where it is no longer a major public health problem in the population of Tanzania Mainland, with special attention to the most vulnerable groups: children under five, pregnant women and the poor. To contribute towards achieving this goal, NMCP needs to continue to deploy effective interventions such as use of ACTs for malaria treatment, scaling up of LLINs, Behavioral Change Communication and Surveillance, Monitoring and Evaluation. Following the deployment of these interventions nationally, it became necessary to evaluate the progress in the implementation and the impact of these interventions on the malaria burden(CAG Report 2017).

As we embark on the ambitious goal of taking Tanzania Mainland from malaria control towards elimination, the Ministry of Health and Social Welfare (MOHSW) in collaboration with RBM partners decided to carry out a comprehensive midterm

programme review to identify achievements, bottlenecks, and best practices to guide the future of malaria control programming. While malaria remains a major public health and development challenge in Tanzania Mainland, a unique opportunity exists to scale up malaria-related interventions, strengthen health systems, and make a major effort to roll back malaria in the country. Malaria currently accounts for nearly 12.8 million clinically diagnosed cases per year (Source: THIMS 2010), 40% of outpatient department visits and up to 29% of total deaths, 20% being caused duringmaternal.In addition to the direct health impact of malaria, there is also a serious social and economic burden on the communities especially the poorest and those vulnerable individuals.

Thus, malaria control is addressed, not as a separate, vertical, disease-specific intervention but as part of a health systems strengthening effort to provide holistic services in all facets of care, and as part of a larger community development effort. Through the National Malaria Medium Term Strategic Plan 2008- 2013, the Government and many Roll Back Malaria (RBM) partners are committed to increasing coverage of key malaria control interventions and reducing the burden of malaria throughout the country. The Ministry of Health and Social Welfareøs organizational structure comprises of the Minister for Health and Social Welfare, the Deputy Minister for Health and Social Welfare, the Permanent Secretary and the Chief Medical Officer with five directorates.

Those directorates include: Preventative Services, Curative Services, Human Resource Development, Policy and Planning, and Administration and Human Resource Management. Government owned facilities at regional and district/council

levels are administered through the Prime Ministerøs Office for the Regional Administration and Local Government (PMORALG). Malaria on the national development agenda is still the number one killer disease in children aged less than five years and a significant contributor to maternal mortality. It is also the leading disease in terms of health facility attendance, thereby contributing to the heavy workload of the scarce and overstretched human resources for health(Jope, 2018).

In economic terms, the losses incurred by the country as a result of malaria if translated in monetary terms can be to the tune of 121 USD millions, which otherwise, would have gone into other development investments. It thus became mandatory that, an ambitious strategic plan, for the elimination of malaria is conceived to make it a reality. National and international resolutions for malaria control and elimination was formulated and supported. õThe Ministry of Health and Social Welfare came up with the second strategic Plan, (2008-2013) with a focus on õmalaria eliminationö in line with the global initiative that advocates for a radical scaling up of interventions to achieve the Roll back Malaria targets of universal coverage of 80% by 2010 and the Millennium Development Goals by 2015.ö

Table 4. 6: Physical Performance of the National Malaria Control Programme Global Fund Round Eight Project

	GRANT PHYSICAL PERFOMANCE				
Target Description	**Final Budget**	**Actual releases (Global Fund)**	**Actual Expenditure**	**Varience (Approved Budget Vs Actual Expenditure)**	**Varience (Actual releases Vs Actual Expenditure**
1	2	3	3	4	5
Distribution of LLINs to household throughamasss campaign	19,351,780	19,351,780	18,351,780	18,351,780	1,065,379
LLINs issuing through a logistic contractor	294,863	294,863	294,863	294,863	-
Training and sensitization of local government officials to conduct the Universal Coverage Mass Distribution Campaign	615,145	615,145	615,145	615,145	-
Create Demand for free distribution of LLINs and raise the profile of malaria through Mass Media, create demand for free distribution of LLINs and raise the profile of malaria through Community Outreach	151,267	151,267	151,267	151,267	-
To strengthen the capacity of 21regional health management teams to supervise the implementation of malaria prevention and control activities at District level.	1,006,096	1,006,096	940,717	940,717	
To audit the Universal Coverage Campaign, evaluate ITN and LLINs distribution mechanisms and	123,266	123,266	123,266	123,266	-

	GRANT PHYSICAL PERFOMANCE				
Target Description	**Final Budget**	**Actual releases (Global Fund)**	**Actual Expenditure**	**Varience (Approved Budget Vs Actual Expenditure)**	**Varience (Actual releases Vs Actual Expenditure**
policy options for maintaining long term Universal coverage within six months of the conclusion of the Under-five and Universal Coverage Campaign.					
TOTAL	21,542,417	21,542,417	20,477,038	20,477,038	1,065,379

Source *:* Financial statements and CAG reports for the financial years**.**

Table 4.7 shows that for the financial years 2015/2016 and 2016/2017 only 90% and 19% of the total budget were respectively received, but there was an opening balance of USD 17,880,890.00 (equivalent to TZS. 27,914,016,518.90) from previous year to be used in the financial year 2011/2012.

Table 4. 7: National Malaria Control Programme Global Fund Round Eight Projects under Grant Agreement TNZ-809-G11-M

Financial years	**Approved Budget (TZS.)**	**Amount received (TZS.)**	**Percentage of amount received against the approved budget**
2015/2016	USD 100,427,017 (equivalent to TZS. 156,777,510,039.04)	USD 90,517,686 (equivalent to TZS141,307,965,221.90	90%
2016/2017	not exceed US$ 20,707,304 equivalent to TZS 32,386,223,456.00	Opening balance was USD 17,880,890.00 (equivalent to TZS.27,914,016,518.90) and USD 3,854,187.00 (equivalent to TZS 6,016,805,627.96) were received during the financial year 2011/2012	19%

Source : Financial Statements and CAG Reports for the Financial Years

Data from interview also showed that theNational Malaria Control Programme Global Fund Round Eight Projects under Grant Agreement TNZ-809-G11-M received almost all of the agreed amount as one of the interviewee was quoted and confirmed on CAG reports for the financial years 2010/2011 to 2011/2012.

*"We have an number of health projects but for National Malaria Control Programme Global Fund Round Eight Project was accomplished to the facet fact the approved budget was received as planned. As for the malaria project has been implemented by 90% for the financial year2015/2016 and for the financial year2011/2012, the project was implemented by 94% when comparing the approved budget against the expenditure*ö said the Distric Medical Officer.

4.3 The National Tuberculosis and Leprosy Programme in Kinondoni Municipal Council

The second objective to this study was to assess the national tuberculosis and leprosy program achieved due to foreign budget support in Kinondoni Municipal council. The analysis was done and presented in the subsections below. The findings shows that under the health sector wasGlobal FundNational Tuberculosis and Leprosy programmeRound Three and Six**.** The Ministry of Health and Social Welfare launched the National Tuberculosis and Leprosy Programme (NTLP). The Program is charged with the responsibility of facilitating early diagnosis, treatment and cure of as many tuberculosis and leprosy patients as possible so as to reduce the incidence and prevalence of these diseases until they are

no longer a major public health problem in the country and to reduce physical disability and psycho-social suffering caused by the two diseases. (CAG reports for the financial years 2015/2016 to 2016/2017)

The financial statements for the year ended 30th June 2016 for Global Funds National Tuberculosis and Leprosy programmeRound Three and Six shows Global Fund (GFATM) grant proceeds administered under National Tuberculosis and Leprosy Programme (NTLP) for TB and TB/HIV. The NTLP is Lead sub recipient of Global Fund Round Six Grant No TNZ- 607-G09 óT and is charged with administrative oversight of implementation for both the TB and the Health Systems Strengthening component (HSS) of this grant. This five year grant was approved for USD 35,111,404.(finacial statement and CAG reports for the year 2015/2016, 2016/2017)

Phase 1 started in 1st November 2007 and ended in 31st October 2009 in which USD 16,498,948 were approved but up to end of phase I a total of USD 15,112,888.53 were disbursed. Phase two was approved but no funds were disbursed up to 30th June 2011. Expenditures in this period relate to phase I carried over activities and carried over funds.NTLP was sub recipient of Round Three Grants No.TNZ -304 ó G03 óC whereby NTLP received a total of TZS 647,000,000 over five years since year 2006 for the TB component of this grant. The grant closing date was 30th April 2010 but expenditures for salary of contracted staff extended to September 2010(CAG reports for the financial years 2015/2016 to 2016/2017).

The objectives of National Tuberculosis and Leprosy Programme among others are:- To increase case detection and cure rates of TB and leprosy patients by 5% and to reduce disability grade II of newly diagnosed leprosy patients by 5% ,to integrate

NTLP activities at different levels to conform to the ongoing Health Sector Reform ,to develop human resources and strengthen management of TB and leprosy service delivery at all levels, to implement TB/HIV collaborative programme activities in collaboration with National Aids Control Programme (NACP) and other stakeholders, to establish management of multi-drug resistant tuberculosis,(MDR-TB) in the country,to strengthen the quality of NTLP management information system with gender mainstreaming at all levels and to determine and monitor the magnitude of TB/HIV and leprosy burden in Tanzania(Kao, 2016)

Notified new and relapse TB cases were 64053 in 2017. The notification of TB cases per 100,000 population increased in the late nineties due to HIV, up 159/100,000 in 2008 then dropped steadily during the last decade to 140/100,000 in 2011 and increased slightly to 142/100,000 in 2013, although the notification of smear positive TB cases did not drop as sharply as all TB cases.13 Although the notification of TB cases per population is decreasing, the total number of TB cases in 2012 remained essentially the same as in 2013. Both in 2013 as well as ten years later, 25,000 smear positive TB cases were notified, with 65,732 TB cases overall in 2013 and only 1,000 fewer cases notified in 2012. The estimated case detection rate rose from 2011 to 79% in 2013 14. The preliminary prevalence survey indicates that a large proportion of TB cases are undiagnosed, and the decline in notification rates may be the result of stagnation in increased capacity of TB diagnosis in the country. The regional trends indicate large differences in case notification within the country; a signal that there is probably still substantial under diagnosis and underreporting in some regions. The contributions are in brackets for the Dar-es-Salaam (21.8%).

TB case (all forms) detection rate increased from 75% (2008) to 79% (2012); the target was 80% by 2015 with age-sex distribution of 59.4% male and 40.6% female (1:1.4). The majority of notified TB cases belong to the age group of 15-44 years, the same age group most affected by HIV and AIDS. TB treatment success rate for all categories of TB was 85% (2012) however; there are regional variations from 71% in Singida to 98% in Lindi. Nationally the death rate fell from 5% (2008) to the targeted 4% in 2015. The retreatment cases notified in 2012 were 4.3% of all cases notified, which was a decline from 5.8% compared to 2011 with treatment success rate of 82%.23

The increased in detection rate was partly attributable to the availability of basic infrastructure across the country for finding TB cases, such as an increased number of AFB microscopy centres (from 720 [2008] to 945 [2012], and increased number of public laboratories with the capacity to perform TB culture (from one to five laboratories) and the introduction of new TB diagnostic tools (2 liquid cultures, 5 HAIN and 51 Xpert MTB/Rif machines). First line medicines for treating tuberculosis are available in most health facilities and stores at all levels, secured and no out of stocks of drugs and supplies.

Over the last 5 years, about 5,000 cases of childhood TB were notified annually accounting for 8-10.6% of all TB cases in the country, but less than 2% of smear positive cases. Data aggregated from 6 of 11 regions where health workers were trained on childhood TB showed a steady increase in notification from 8.6% to 11.3% between 2012 and 2013. NTLP has taken advantage of Xpert MTB/Rif rollout to improve case detection by including children in the algorithms. HIV infected

children receive comprehensive HIV care, while IPT is provided to HIV positive children with no active TB and children under five years of age who are close contacts of smear positive TB cases.

By the end of 2013, the National Centre of Excellence (CoE) for MDRTB management in the country established at Kibongøoto hospital in Kilimanjaro region had admitted 210 MDR-TB cases. The hospital performs culture and molecular diagnostic testing (Hain Test and GeneXpert MTB/Rif) since 2013. Since 2009 to the first two quarters of 2014, the program had enrolled 286 MDR TB patients. On average 48% of the patients with MDR-TB were co-infected with HIV and 9% of these were children less than 15 years. Most of the cases were already diagnosed from source districts before reaching the MDRTB Hospital.

According to the annual TB report of 2012, the majority of MDR TB cases diagnosed and started on treatment were from Dar es salaam (62%) followed by Tanga (9%), Mwanza (9%) and Mtwara (4%). The location of the CTRL and a suboptimal sputum specimen referral system may result in more MDR TB cases detected from Dar esSalaam. The average treatment success rate to date is 75% (which is one of the highest in the African Region) and mortality is 20% in cohorts which have completed treatment so far.24 Most deaths occur among those not co-infected with HIV during the first two months of treatment most likely due to delays in referrals. To date, no XDR-TB cases have been diagnosed in Tanzania.
TB/HIV coordinating committees have been formed in 23 regions and 133 Districts in Tanzania mainland to oversee collaborative TB-HIV services. In 2012, 82% of all notified TB cases was tested for HIV, among them 39% tested HIV positive and 96%

and 54% of the latter were initiated on Cotrimoxazole Preventive Therapy and ART respectively.25 TB screening occurs routinely in greater than 95% of People Living with HIV at Care and Treatment Clinics (CTC). In addition, Isoniazid Preventive Therapy (IPT) for PLHIV has being implemented in phases in 20 CTC in the period 2010 to 2014 and has recently been scaled up to 104 CTC countrywide.

Tanzania has maintained the global target of Leprosy elimination at national level of less than 1/10,000 population during the current strategic plan. Treatment success rates of leprosy patients have been maintained at over 90% for both Multibacillary (MB) Paucibacillary (PB. In 2012 the prevalence rate was 0.46 cases per 100,000 populations where the number of new cases was 2528 in 2012, giving a detection rate of 5.61 new cases per 100,000 population. The proportion of children detected among the new cases has been declining from 10% to 5.2%. However, 11.9% of newly diagnosed cases had disability grade two.

Community mobilization activities on TB have empowered TB patients to participate in TB and TB-HIV control activities. Currently, there are 400 CBOs (ex TB patients groups) and one NGO reporting TB case notification. The data received in 2012 indicates that 35% of presumptive TB cases and 14% of notified TB cases were referred by Community Health Workers in 2012. Furthermore, over 75% of patients are choosing home-based TB treatment support which has reduced congestion at TB clinics and transport costs for TB treatment. Treatment success among these patients is 89%, the same as those observed at the facility. Through the ENGAGE TB approach, NGOs active in community care are encouraged to address TB control activities.

Table 4. 8: Physical Performance of the National Tuberculosis and Leprosy Program

Strategic objective/ SDA	Planned Activity	Planned target	Achieved target	Achieved %
(a)		(b)	(c)	(d)
Objective 1 SDA 1: TB/HIV collaborative activities: Prevention of HIV in TB patients	1.1.8 Conduct mid and end-term evaluation of TB/HIV activities	Mid and End-term evaluation of TB/HIV activities Conduct	TOR developed for End term evaluation	25%
	1.1.17 Conduct refresher training of health workers on TB/HIV including DCT	465 health workers to receive refresher training on TB/HIV and DCT	800 health workers received refresher training on TB/HIV and DCT	172%
	1.1.18 Provide enablers to improve working environment of TB/HIV staff	Enablers provided to staff working with TB/HIV patients	Funds to provide enablers disbursed to all 36 districts	
	1.1.20 Provide Isoniazid Preventive Therapy (IPT) for AIDS patients	7426 tins of Isoniazid procured	Invoice requested from MSD.	
Objective 1 SDA 2: TB/HIV collaborative activities: Provision of antiretroviral treatment for TB patients during TB treatment	1.2.1 Recruit TB/HIV clinicians	31 clinicians recruited	Not done	
	1.2.2 Recruit TB/HIV nurses	31 clinicians recruited	Not done	
	1.2.3 Recruit TB/HIV training coordinator	1 TB/HIV training coordinator recruited	1 TB/HIV training coordinator recruited	
	1.2.4 Recruit data management personnel at central level	1 data management personnel recruited	1 data management personnel recruited	
	1.2.5 Recruit an accountant to support TB/HIV activities	1 accountant and 1 assistant accountant recruited	1 accountant and 1 assistant accountant recruited	
	1.2.6 Recruit administrative assistant at the central level	One administrative assistant recruited	Not done	
	1.2.7 Recruit a driver	One driver recruited	Not recruited	
	1.2.8 Train health workers on ART provision	210 Health care providers trained	245 Health care providers trained	117%
	1.2.9 Conduct supportive supervision	31 districts supervised twice per year	Funds to supervise 36 districts twice per year disbursed to	

Strategic objective/ SDA	**Planned Activity**	**Planned target**	**Achieved target**	**Achieved %**
(a)		(b)	(c)	(d)
			SSRs	
	1.2.10 Seek technical assistance from WHO,KNCV,CDC and other partners	Technical assistance requested on TB/HIV	Contract awarded to consultant to review TB/HIV ACSM strategy	
	1.2.11 Update and refurbish diagnostic and DOT centers	69 diagnostic and DOT centers refurbished	Contract with Tanzania Building Agency signed for refurbishment works	
Objective 1 SDA 3: Strengthening NTLP Monitoring and Evaluation System	1.3.1 Infrastructure, Human resource, data tool and guidelines, training and supervision	M&E system in place	M&E staff paid salaries and trained, M&E tools developed	
Objective 1 SDA 4: Conduct National Tuberculosis Prevalence Survey	1.4.1 As per survey protocol and detailed budget in collaboration with NIMR	50% of the sampled clusters surveyed	50% of the sampled clusters surveyed	
Objective 2 SDA. 1 : Community TB care (CTBC)	2.1.3 Conduct joint planning	7 region and 31 district joint plans developed	7 region and 36 district joint plans developed	
	2.1.4 Recruit CTBC focal person at the central level	CTBC focal person at the central level recruited	CTBC focal person at the central level recruited	
	2.1.6 Facilitate quarterly meetings for community based providers	Meetings conducted	Each council provided with funds to support quarterly meetings for community based providers	
	2.1.7 Facilitate TB patients and former TB patients to form social support groups.	Hiring local consultant to document Muleba Experience	Contract signed with local consultant to document MulebaExperience	
	2.1.10 Provide incentives and enablers to community based providers	Incentives and enablers provided	Funds disbursed to 36 districts to provide incentives and enablers	
	2.1.11 Document best practices on community TB care	Document best practices on community TB care	TOR developed, contract yet to be signed	
	2.1.15 Procure bicycle for community TB care providers	Bicycles procured	36 districts provided with funds to procure	

Strategic objective/ SDA	Planned Activity	Planned target	Achieved target	Achieved %
(a)		(b)	(c)	(d)
			bicycles	
	2.1.16 Maintain bicycle in running condition	Bicycles maintained	Funds disbursed to 36 districts	
Objective 2 SDA 3. BCC: Mass media	2.3.8 Conduct evaluation of BCC strategy	Evaluation conducted	Not done	
Objective 3 SDA 1: Public-Private Mix	3.1.2 Conduct needs assessment of Private health facilities			
	3.1.9 Procure and distribute microscopes to both diagnostic and DOTS centers within the private sector	21 Microscopes provided to private health facilities implementing DOTs	Not done	
	3.1.10 Procure and distribute supplies and laboratory reagents	Supplies and laboratory reagents Procured for DOTS centers	Not done	
	3.1.11 Conduct supportive supervision including quality control of AFB microscopy	Regions and districts supervised by Central level	Not done	
Objective 2	4.1.1 Recruit staff for MDR-TB (5 people: 1 medical officers, 2 nurses and 2 lab.technicians)	2 Medical Officers, 2 Nurses and 2 Lab staff recruited	Staff recruited and retained	
	4.1.2 Recruit drivers for MDR-TB (1people)	Driver recruited	One driver recruited and maintained	
	4.1.5 Upgrade and refurbish Kibongoto hospital including lab services (1steriliser room, 2 wards and 1 MDR-TB laboratory)	Kibongøoto Isolation wards refurbished	Isolation wards drawings and contracts under review	
	4.1.6 Procure and install laboratory equipment (Florescent microscopes, Safety cabinet, air concentrators, air extract fans, hot air oven, autoclave, inspissator, incubators, water bath, special masks, centrifuge machine etc)	TB laboratory equipment for CTRL and Kibong'oto procured	Not done	
	4.1.7 Maintain laboratory equipment	Maintain laboratory equipment	Funds disbursed to Kibong'oto TB Hospital	
	4,1.8 Procure and dIstribute laboratory supplies and consumables	Laboratory supplies and consumables	Funds disbursed to Kibong'oto TB Hospital	

Strategic objective/ SDA	Planned Activity	Planned target	Achieved target	Achieved %
(a)		(b)	(c)	(d)
		procured and distributed		
	4.1.12 Train national team and regional coordinators on MDR-TB	120 coordinators at regional and district levels trained	Not done	
	4.1.13 Special training of care providers	MDR-TB training to 6 staff provided (medical officer, nurse).	Not done	
	4.1.14 Support referral of MDR-TB patients and specimens	MDR-TB patients referred to Kibong'oto	MDR TB patients have been referred to Kibongot'o	
	4.1.15 Provide food and essential requirement to MDR-TB patients	Food and essential requirement provided to MDR-TB patients	Food and essential requirement provided to MDR-TB patients	
	4.1.16 Procure DOTS Plus drugs through Green Light Committee (GLC)	MDR-TB drugs procured	MSD engaged to procure drugs for MDR TB patients	
	4.1.17 Clearance of drugs, storage and distribution	MDR-TB drugs for 30 patients delivered at Kibong'oto hospital	MSD engaged to clear drugs for MDR TB patients	
	4.1.18 Contribute to the costs of services by Green Light Committee (GLC)	Consultancy services purchased from GLC	GLC costs paid	
	4.1.19 Supportive supervision	Supportive supervision conducted	Not done	
	4.1.20 Central Administration	Office administrative costs provided	Office administrative support provided	
Objective 5 SDA 1. Testing and counseling	5.1.1 Dissemination meeting on Provider Initiated Testing Counseling Guidelines and SOP to RHMTs , CHMTs and Private Sector			
	5.2.1 Expand storage capacity in Dar es Salaam, Dodoma, Mbeya, Tabora and Mtwara Warehouses	Expand storage capacity in Dar es Salaam, Dodoma, Mbeya, Tabora and Mtwara	Tender document prepared, advertised, bid evaluated and contracts awarded to	

Strategic objective/ SDA	Planned Activity	Planned target	Achieved target	Achieved %
(a)		(b)	(c)	(d)
		Warehouses	successful bidders	
	5.3.2 one 4-wheel drive vehicle and working tools for the central office	One 4-wheel drive vehicle and working tools for the central office	One - 4 wheel drive vehicle (Nissan Patrol) has been procured.	

Source : Financial Statements and CAG Reports for the Financial Year

Table 4. 9: The National TB and Leprosy Programmereceived the following amount for both Round Three and Six of Global Fund as detailed

Financial year	Approved Budget (TZS)	Amount received (TZS)	Percentage of fund received against the approved budget
2015/2016	7,220,715,324	no funds were disbursed up to 30th June 2016. Carried over funds. Was used to finance carried over activities Balance from the previous years (Round Three Shs.131,698,163 Round Six Shs .5,804,044,324)	0
2016/2017	**8,080,488,975.93**	**6,867,987,191.99**	**85**

Source *:* Financial Statements and CAG Reports

During the financial year 2015/2016 the National TB and Leprosy Programme approved budget was TZS. 7,220,715,324 but nothing was disbursed from the Global and carried over funds were used to finance carried over activities and for the

financial year 2011/2012,85% of the approved budget was received and only 15% of the approved budget was not received.

4.4 HIV/Aids Prevention Achievements Goals in Kinondoni Municipal Council

The last objective to this study was to assess the HIV/AIDs prevention achievement goals due to foreign budget support in Kinondoni Municipal council. The analysis was done and presented in the tables 4.11. The findings shows that one of the project under the health sector was Global Fund- Tanzania Commission for AIDS. Tanzania has benefited from the GFATM since 2003 in a way that it has received a total of USD 776,497,283 out of USD 1,872,371,525 signed GF grant. The GFATM funding is a grant that Tanzania receives from GF Development Partners to implement various interventions related to HIV/AIDS, Tuberculosis (TB) and Malaria in mainland Tanzania.

The Tanzania Commission for AIDS is the coordinator of the GF in Tanzania while it draws its mandate for the same from the Tanzania National Coordinating Mechanism (TNCM). Four representatives from the Development Partners sit in the TNCM, under the chairmanship of the Permanent Secretary -Prime Ministerøs Office.Review of the National HIV and AIDS Policy 2001, the International programs were coordinated. UN-Joint, NMSF Grant, Global Fund, SADCC and East Africa Projects,training to TACAIDS staffon Planning and budgeting and procurement process,review Risk Management Register,National Research and Evaluation Agenda,TOMSHAtraining,World AIDs Day Commemoration,Review of

Public Relation Guide,Launch of the National HIV and AIDS Communication Advocacy Committee and TACAIDS resource center was improved. Table 4.10 shows the analysis of revenue from the government and donors grants of TACAIDS on the development account.

Table 4. 10: Analysis of Revenue from the Government and Donors Grants of TACAIDS

Financial years	Approved Budget (TZS)	Amount received (TZS)	Percentage of fund received against the approved budget
2010/2011	20,648,509,698	10,416,424,951	50
2011/2012	19,389,608,118	17,473,220,162	90
2012/2013	15,463,050,798	6,934,079,123	45
2013/2014	15,344,335,000	11,388,906,064.70	74

Sources: Financial Statements and CAG Reports for the Financial Year2010/2014

The table 4.11 shows that, contribution from the government and donors grants on TACAIDS development activities, for the four years from 2010/2011 to 2013/2014, Percentage of fund received against the approved budget were 50%,90%,45% and 74% respectively.The last project under the health sector was Health Systems Strengthening Global Funds Round Nine. The Ministry of Health and Social Welfare is the lead recipient of the Health Systems strengthening Global Fund Round 9 Grant No. TNZ-911-G14-S. The Government of Tanzania`s commitment to equitable delivery of quality health services faces major challenges relating to operating without the necessary skilled staffing levels, an inability to recruit and retain as many health workers as are required, low training capacity, poor procurement systems, and a disintegrated health information system. The objectives of the programme is to increasing health workforce production ,improving workforce attraction and

retention; strengthening use of quality health information systems for planning and monitoring; strengthening procurement, storage, and quality assurance of medical products; and improving system governance and stewardship in particular: To increase production of mid ó level and highly skilled health workers in Tanzania`s existing public, private, and faith ó based training facilities.

Scaling óup tested country health human resource innovations to support recruitment, strengthen retention to improve services delivery in HIV, TB and Malaria and other health services. To increase evidence-based decision-making at district, regional and national level. To improve efficient and effectiveness in procurement, storage and distribution of quality health products and services. To create comprehensive health systems leadership and management capacity to effectively manage HIV/AIDS, TB, and Malaria. The Health Systems Strengthening (HSS) is financed by the Global Fund Grant to the United Republic of Tanzania as shown in table 4.11.

Table 4. 11: Health Systems Strengthening Global Funds Round Nine

Financial year	Description	Amount received (TZS)
2010/20 11	Fund Received from Global Fund	4,132,081,949.80
2011/2012	Fund Received from Global Fund	9,276,884,493
2012/2013	Fund Received from Global Fund	24,896,877,387.00
2013/2014	Fund Received from Global Fund	7,843,312,820.24

Source: Financial Statements and CAG Reports for the Financial Years above.

Tanzania Mainland is experiencing a generalized HIV epidemic in the general population. The epidemic is concentrated among key Population groups. According to the HIV and AIDS population surveys (THIS and THMIS), HIV prevalence is

showing a declining trend in the general population among adults aged 15-49. The prevalence has declined, from 7.0% in 2003/04 to 5.7% in 2007/08to 5.1% in 2011/2012. HIV prevalence varies by regions and within region, Njombe region has the highest HIV prevalence at 14.8%, the lowest prevalence is recorded in Manyara region at 1.5%.Women are disproportionally affected by the epidemic; HIV prevalence is higher among women than men in all age groups. By the end of 2012, the estimated number of people living with HIV was 1.6 million and a total of 68,447 newly HIV infected people aged 15-49 years.(CAG report 2012/2013)

In Tanzania Mainland, evidence suggests that specific populations are at increased risk for HIV infections, including injecting drug users (IDUs), Men who have Sex with Men (MSM), females sex workers (FSW). Several studies have found high rates of HIV infections among IDUs, female bar workers and female sex workers. Among Female Sex Workers in Dar es Salaam, HIV prevalence has been reported to be as high as 31.4% (BSS 2010).

HIV prevention initiatives are very critical for containing the epidemic. The country has continued to implement programs on PMTCT, HIV Testing and Counseling, Home Based Care, Voluntary Medical Male Circumcision, condom promotion and programming, diagnosis and treatment of sexually transmitted infections, Behavior Change Communication, provision of comprehensive sexual and reproductive health, HIV and AIDS and life skills education through peer education particularly for in and out of school youth. Health facilities providing HIV care and treatment services have increased from 1,112 in 2011 to 1,176 by the end of December 2012. A total of

1,135,390 PLHIV were cumulatively enrolled in care and treatment services and 663,911 eligible adults and children were cumulatively put on ART and 432,338 were currently on ART. The cumulative percentage on ART as of December 2012 was 58.4 (663,911/1,135,390) and currently on ART was 84.2 (432,338/513,359). The cumulative number of children enrolled in care and treatment was 86,929 and a total of 50,980 of children were put on ART (this accounts for 7.7% of the cumulative number of all clients ever on ART). In this reporting period a total of 82,811 pregnant women tested positive for HIV. The number of infants tested positive for HIV was 2,328, which is 2.8% of all the HIV exposed infants.(Financial statement and CAG report for the year 2012/2013)

The Private Sector through the Association of Tanzania Employer and Engender health/CHAMPION has continued to strengthen capacity among employers to implement HIV and AIDS workplace interventions. Civil Society Organizations have continued to play an important role in the response to the HIV epidemic. Currently there are over 6,000 (six thousand) community and civil society organizations that provide HIV and AIDS services to communities in Tanzania. The services include HIV prevention, care and support, impact mitigation and advocacy.

Gender inequality and gender based violence have been cited in different reports to have contributed to HIV infections. The Government of Tanzania in collaboration with partners has developed and disseminated the National Gender Operational Plan for HIV response (2010-2012). The plan provides framework for stakeholders for mainstreaming gender in all HIV and AIDS interventions. The M&E plan for Gender

Operational Plan and data collection tools are being developed. Gender and Children Desks are established in 417 police stations throughout the country and 917 Police officers working in Gender and Children Desks have been trained on provision of services to GBV and VAC survivors.(TACAIDSreport for the year 2010/2011, 2011/2012)

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This section concludes the study, it highlights some policy implications as a result of the researchøs findings and general recommendations as regards to the study.

5.2 Summary of the Study

This study was carried to assess the contribution of foreign budgetary support on health goals achievement in Kinondoni Municipal Council .The study was guided by three research objectives and three research questions which have been as key guide in the whole of this research paper.In chapter two, a number of concepts, ideas as well as different illustrations were presented so as to give knowledge on the way forward of the research by identifying, the research gap, conceptual framework and empirical analysis. This study was a case study. The study used the population from Kinondoni Municipal. The study had a sample size of 27 respondents. The study used purposive sampling techniques in obtaining the sample size. In this study, data was collected through questionnaires and documentary review. The researcher used both qualitative and quantitative data in data presentation in chapter four and thereafter a discussion of the study findings was made.

5.3 Conclusion

The findings shows that there are different projects which have been funded by donor countries to budget support in Tanzania . The findings shows that in health sector the selected five projects were fully funded by the development

partners, these projects are DANIDA program, the National Malaria Control Programme Global Fund Round Eight Project, National Tuberculosis and Leprosy programme Global Fund Round Three and Six, Global Fund- Tanzania Commission for AIDS, and Health Systems Strengthening Global Funds Round nine,however, one of the main challenges which hinder effective budget support is delay of funds from the donors .

It has been found that in almost every project there has been a delay of funds which leads to failure of accomplishment of projects also in most projects the amount received is less than what has been approved in the budget or what has been agreed to be disbursed. National Malaria Control Programme is well set for management and operationalization of the Malaria Medium Term Strategic Plan. There is political will and commitment from the government at the highest level. The programme is supported by development and implementing partners. At the regional and district levels the malaria programme works through the Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs) respectively.

NMCP is well set for easy management and operationalization of the program. However, with a wide range of implementing partners, technical coordination is a challenge. Some technical working groups are operating, though sub-optimal. NMCP does not develop one integrated annual operational plan in collaboration with partners resulting in inadequate coordination and monitoring of implementation. Communication and information sharing is inadequate. There are insufficient human resources and an inadequate skill mix in NMCP to assume its leadership role in most

technical areas. The governmentøs financial support to NMCP is low, making the programme heavily reliant on external funding.

There is additional protection to the population at risk in IRS targeted areas. Furthermore, population of Dar es Salaam are benefiting from additional larviciding. Rapid Diagnostic Tests (RDTs) have been scaled-up and foreseen to cover the whole nation. In addition to the public sector distribution, access to ACTs has improved in the private sector through the Affordable Medicine Facility for malaria (AMFm). IEC/BCC has contributed to improved public awareness, enhanced community participation, and increased uptake of malaria control interventions. The scale-up of these interventions have contributed to the change in malaria epidemiology.Also, TB case (all forms) detection rate increased from 75% (2008) to 79% (2012); the target was 80% by 2015 with age-sex distribution of 59.4% male and 40.6% female (1:1.4). The majority of notified TB cases belong to the age group of 15-44 years, the same age group most affected by HIV and AIDS. However, with the PST survey (preliminary the case detection rate ranges from 45-54%, indicating that many cases are missed.

Lastly, Tanzania Mainland has implemented various programs towards achieving the global initiatives targeted at zeroing new HIV infections. The HIV prevention interventions in the country include: the Prevention of Mother to Child Transmission (PMTCT), HIV testing and Counseling (HTC), Home Based Care (HBC), Voluntary Medical Male Circumcision, condom promotion and programming, Behavior Change Communication programs (BCC), provision of comprehensive sexual and reproductive health, HIV and AIDS and life skills education through peer education

programs particularly for in and out of school youth. The achievements that have been accorded so far on HIV prevention, is a clear evidence of the existing collaboration between the government and implementing partners including MDAs, CSOs, NGOs and Development Partners.

5.4 Recommendations

i. It is recommended that the Ministry of Health and Social Welfare in collaboration with stakeholders to take deliberate measures to disseminate and distribute relevant policy documents and subsequently undertake regular reviews and trainings targeting social welfare workers

ii. The Ministry of Health and Social Welfare in collaboration with stakeholders undertake capacity building targeting social workers to enhance their capacity on responding to the need of the general public at local government levels.

iii. That in collaboration with stakeholders more social workers should be trained/ recruited,

iv. To Formulate strategies for developing a social welfare policy which should define all elements of social welfare service provision need to be laid.

v. Donors to continue supporting the government of Tanzania in development activities in order for the government to overcome development challenges until the government manages to finance full its budget.

vi. Donorsto continue assistingthe government in seeking long-term, sustainable financing mechanisms in order to make the removal of user fees possible. Donors should follow the WHO code of practice on the international recruitment of health personnel and ensure that both their development and

non-development-related programmes and projects do not have a negative impact on the workforce in the health sector in developing countries.

vii. Management of ministries is advised to ensure that follow up are done in order to ensure that fund are received as per approved budget.

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APPENDICES

Appendix 1: Questionnaires

Dear Respondent, I am a final year student at Open University of Tanzania. I am pursuing masters of International Cooperation and Development. I am carrying out a study on; An assessment of the contribution of foreign budgetary support on health goals achievement in Kinondoni Municipal council. This study is strictly for academic purposes and the information will be conducted with much confidentiality. Please, I ask for your corporation Here, I would like to have some personal information about you óundoubtedly for analytical purpose.

Part A: The health achievement made on malaria control due to foreign budget support in Kinondoni Municipal council

1. Does Kinondoni municipal receive foreign budget support for Malaria control ?
   a) Always
   b) Sometimes
   c) Rarely
   d) Never
2. What areas are mostly targeted for the Malaria control from the foreign budget support?
   a) Health centers/ hospital construction
   b) Vaccines
   c) Medication
   d) Education provision of different health issues to the public

e) Support for the education of health stakeholders (Doctors and Nurses)

3. In what form does the foreign aid come for Malaria control?

   a) Loans/Grants

   b) Mere support

4. Where does mostly foreign budget support for Malaria control come from?

a) Donor countries

b) IMF

c) WHO

d) EU

5. At what rate does the foreign budget support come for Malaria Control ?

   a) 1% to 5 %

   b) 5% to 10%

   c) 10% to 15%

   d) 15% to 20%

   e) 20% to 25%

   f) 25% to 30%

   g) 30 to 35%

   h) 35% and above

6. Does the foreign budget support come as promised for Malaria control?

a) Always

b) Sometimes

c) Rarely

d) Never

7. Is the foreign budget support directed to areas for Malaria control as planned?
    a) Always
    b) Sometimes
    c) Rarely
    d) Never

PART B: The HIV/AIDs prevention achievement goals due to foreign budget support in Kinondoni Municipal council

8. Does Kinondoni municipal receive foreign budget support for HIV/AIDs prevention?
    e) Always
    f) Sometimes
    g) Rarely
    h) Never
9. What areas are mostly targeted for the HIV/AIDs prevention from the foreign budget support?
    f) Health centers/ hospital construction
    g) Vaccines
    h) Medication
    i) Education provision of different health issues to the public
    j) Support for the education of health stakeholders(Doctors and Nurses)
10. In what form does the foreign aid come for HIV/AIDs prevention?
    c) Loans/Grants
    d) Mere support

11. Where does mostly foreign budget support for HIV/AIDs prevention come from?

    a) Donor countries

    b) IMF

    c) WHO

    d) EU

12. At what rate does the foreign budget support come for HIV/AIDs prevention ?

    a) 1% to 5 %

    b) 5% to 10%

    c) 10% to 15%

    d) 15% to 20%

    e) 20% to 25%

    f) 25% to 30%

    g) 30 to 35%

    h) 35% and above

13. Does the foreign budget support come as promised for HIV/AIDs prevention ?

    a) Always

    b) Sometimes

    c) Rarely

    d) Never

14. Is the foreign budget support directed to areas for HIV/AIDs prevention as planned?

a) Always

b) Sometimes

c) Rarely

d) Never

PART C: The national Tuberculosis and Leprosy programme achieved due to foreign budget support in Kinondoni Municipal council

15. Does Kinondoni municipal receive foreign budget support for Tuberculosis and Leprosy programme?

a) Always

b) Sometimes

c) Rarely

d) Never

16. What areas are mostly targeted for the Tuberculosis and Leprosy programme from the foreign budget support?

a) Health centers/ hospital construction

b) Vaccines

c) Medication

d) Education provision of different health issues to the public

e) Support for the education of health stakeholders(Doctors and Nurses)

17. How does the foreign aid come for Tuberculosis and Leprosy ?

a) Loans/Grants

b) Mere support

18. Where does mostly foreign budget support for Tuberculosis and Leprosy

programme come from?

a) Donor countries

b) IMF

c) WHO

d) EU

19. At what rate does the foreign budget support come for Tuberculosis and Leprosy programme ?

a) 1% to 5 %

b) 5% to 10%

c) 10% to 15%

d) 15% to 20%

e) 20% to 25%

f) 25% to 30%

g) 30 to 35%

h) 35% and above

20. Does the foreign budget support come as promised for Tuberculosis and Leprosy programme ?

a) Always

b) Sometimes

c) Rarely

d) Never

21. Is the foreign budget support directed to areas for Tuberculosis and Leprosy programme as planned?

a) Always

b) Sometimes

c) Rarely

d) Never

PART D: The challenges hindering effective foreign budgetary aid management in Kinondoni Municipal

22. Does the Foreign budget support come as promised ?

a) Always

b) Sometimes

c) Rarely

d) Never

23. Is there accountability on the foreign aid support ?

a) Very high

b) High

c) Low

d) Very low

e) Not at all

24. Is any delay on the foreign budget support ?

a) Always

b) Sometimes

c) Rarely

d) Never

25. As there anyconditionality on the foreign budget support to Kinondoni Municipal ?

a) Very high

b) High

c) Low

d) Very low

e) Not at all

31. Can you identify the conditions given?

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Research Time Timetable / schedule of activities

PARTCULAR S	MONTHS					
	12	1	2	3	4	5	6
Writing the proposal							
Pre-testing of the research tools							
Data Collection Process							
Data Coding and Compilation							
Data Analysis, Interpretation and Report Writing							
Submission of the Report							

Research Budget

Financial Budget according to Nyagawa, P (2001) , is the money required at a stage of work of the research. The research will incurred the following costs.

S/N	PARTICULARS	AMOUNT(TSHS)
	Stationeries Flash diskettes 50000 Rim paper 18000 Pens 7000 Pencil 3000	78,000/=
	Secretarial Photocopy 20000 Printing 30000 Binding 10000	60,000/=
	Personal expenses Meals cost per day 7000 * 12 weeks	588,000/=
	Transport expenses Bus fare 3000*12 weeks	252,000/=
	Other expense Communication	700,00/=
	Total	1,048000/=

Signatures

Studentøs Name: **Esther Sabi** Date 05/10/2018

Comments of the Supervisor

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Supervisor í í í í í í í í í í í í í í Date í í í í í í í í í í í í ..