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THE EFFECTIVENESS OF GOVERNMENT RESOURCES ALLOCATION ON THE QUALITY OF HEALTH SERVICE DELIVERY IN TANZANIA LOCAL GOVERNMENT AUTHORITIES: A CASE OF TARIME TOWN COUNCIL

Werema Zakaria Wambura of Kampala International University in Tanzania, Department of Postgraduate and Research Kampala International University in Tanzania Dar es salaam, Tanzania, P.O BOX 9790 Gongo la Mboto Dare es Salaam, Tanzania, Department of Postgraduate and Research Phone +255673071721 Email: wzakaria31@gmail.com.

Doctor Janet Emily Mutebe of Kampala International University in Tanzania, P.O BOX 9790 Gongo la Mboto Dare es Salaam, Tanzania, Phone +255784293017 Email j.mutebe@kiut.ac.tz

Doctor Fred Masese of Kampala International University in Tanzania, P.O BOX 9790 Gongo la Mboto Dare es Salaam, Tanzania, Phone +255764696469 Email m.fred@kiut.ac.tz.

ABSTRACT

This study examined the effectiveness of government resource allocation on the quality of health service delivery in Tanzania Local Government Authorities, using Tarime Town Council as a case study. Specifically, it assessed the influence of financial resource allocation and determined the distribution of human resources in supporting quality healthcare delivery. The study was guided by the Resource-Based View Theory and the Decentralization Theorem, A descriptive research design was adopted using a mixed-methods approach to obtain both quantitative and qualitative information about resource allocation and healthcare service delivery. The study planned to involve 389 respondents, of whom 369 participated, representing a response rate of 94.9%. Data were collected through questionnaires, semi-structured interviews and documentary review. Quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS), applying descriptive and inferential statistical techniques, including correlation, analysis of variance and regression analysis, while qualitative data were analysed thematically.

The findings revealed challenges in the allocation of financial and human resources. Specifically, 68.3% of respondents disagreed that the health budget was sufficient to support modern diagnostic equipment beyond basic clinical needs, while 64.0% disagreed that the existing distribution of medical staff enabled patients to receive consultations within 30 minutes. Furthermore, 68.6% disagreed that skilled healthcare professionals were fairly distributed between urban centres and remote border wards, and 69.1% disagreed that staffing vacancies were filled promptly to prevent interruptions in critical departments. These findings indicated weaknesses in funding adequacy, equitable staff distribution and timely recruitment, although resource allocation mechanisms received comparatively more favourable assessments.

The study concluded that the quality of health service delivery in Tarime Town Council depended not only on the availability of government resources but also on their timely disbursement, equitable distribution and effective management. Inadequate funding, shortages of skilled personnel and delays in filling staffing vacancies constrained the provision of accessible and reliable healthcare services. The study recommends that the government and Tarime Town Council strengthen the timely release of health funds, improve the obilization and allocation of own-source revenue, prioritise essential medical equipment and supplies.

KEYWORDS: government resource allocation, quality of health service delivery, financial resource allocation, distribution of human resources

INTRODUCTION

On a global level, the discourse on healthcare resource allocation has shifted toward Performance-Based Budgeting (PBB) and data-driven decision-making. International frameworks promoted by the World Bank (2022) and the OECD (2023) emphasize that for health sector to be effective, the authorities must adopt models where resources are allocated based on measurable health outcomes and patient impact. Globally, there is an increasing recognition that local governments are at the frontline of achieving Sustainable Development Goals

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(SDGs), particularly Goal 3 (health and well-being of the people). This necessitates a more robust and transparent mechanism for utilizing resources at the grassroots level to ensure that the global health agenda is localized effectively through strengthened primary healthcare systems (United Nations, 2023).

In developed countries including United Kingdom, resource allocation is characterized by high levels of fiscal decentralization and the use of the Formula Funding mechanism for the National Health Service (NHS). This system utilizes a rigorous needs-based assessment to ensure that even socio-economically disadvantaged councils receive adequate health funding to mitigate regional health inequalities (Local Government Association, 2024). By weighting allocations based on local demographics and morbidity rates, the United Kingdom model attempts to provide a weighted-capitation that ensures clinical quality remains consistent across diverse geographical areas. This institutionalized accountability ensures that financial flows are responsive to actual community needs rather than political patronage (OECD, 2024).

In Germany, resource allocation is governed by the constitutional principle of Konnexitätsprinzip which dictates that if the federal government mandates new health tasks, it must provide the corresponding financial resources to the local authorities. This legal protection prevents unfunded mandates, ensuring that German municipalities can maintain high standards of clinical excellence without straining their local tax bases. This relationship ensures a high degree of synchronization between national health policy and local administrative capacity (Bird & Ebel, 2016).

Within the African context, the effectiveness of healthcare resource allocation varies based on political will and institutional strength. In South Africa, the "Equitable Share" formula is used to redistribute national revenue to provinces and local units to ensure fair service delivery. However, Koelble and Siddle (2020) argue that health service protests remain common because this formula often fails to account for the rapid urbanization of informal settlements. Consequently, while the legal framework for allocation is robust, the actual disbursement often lags behind the demographic shift, leading to overcrowded facilities and a decline in clinical responsiveness.

In Nigeria, local health centers struggle with the state-local joint accounts system, where funds meant for primary healthcare are often stifled by state-level administrative control. Bello-Imam (2021) highlighted that this arrangement creates a vertical bottleneck, where financial resources intended for rural dispensaries are diverted for state-level projects. This systemic lack of direct funding to the grassroots level results in dilapidated clinic infrastructure and chronic shortages of essential medical reagents in localized areas.

In East Africa, data reveals a persistent gap between revenue targets and actual health resource allocations. In Kenya, the health sector has seen a transformation through the "Devolution" model, where at least 15% of national revenue is constitutionally mandated to be sent to the 47 counties. KPMG Kenya (2021) noted that this has significantly improved healthcare access in formerly marginalized areas by allowing counties to build over 2,000 new health facilities since 2013. However, the CRA Report (2024) warned that the pending bills crisis, exceeding KES 150 billion, now threatens to paralyze medical supply chains if fiscal discipline is not restored.

In Uganda, local authorities remain heavily dependent on central grants, as they collect less than 7% of their health budgets from own-source revenues. Smoke (2016) and the LGFC (2022) argue that this dependency forces local health departments to prioritize national agendas over specific local health needs. This top-down allocation logic often leads to a mismatch: rural districts receive equipment for diseases that are not prevalent locally, while lacking resources for their actual epidemiological burdens.

In Tanzania, health resource allocation is also guided by the Local Government Reform Programme (LGRP) and the Formula-Based Budgetary Allocation System (FBBAS). The key policies include the Local Government (District Authorities) Act, Cap 287 and the Local Government Finance Act No. 9 of 1982 and the Direct Health Facility Financing (DHFF) model, which allows funds to flow directly to local health facilities (PO-RALG, 2025). However, this legal mandate is increasingly challenged by central government implementation friction. The Acts grants autonomy to Local Government, the central government exerts control through the Direct Health Facility Financing (DHFF) model and centralized recruitment protocols (PO-RALG, 2025). This creates a vertical imbalance where councils are legally responsible for delivery but remain financially tethered to central treasury disbursements, which are often delayed by 3 to 6 months (Mzenzi, 2021; URT, 2025) and through the central government Direct Health Facility Financing frameworks, roughly 90% of LGA health budgets come from intergovernmental transfers (Massoi & Norman, 2016).

Tanzanian LGAs, including Tarime, face several systemic challenges in health resource allocation including political interference in selecting health projects and delayed disbursement of funds from the central treasury, which disrupts the local medical procurement cycle (Ngware, 2015; URT, 2022). Furthermore, there is a mismatch between the responsibility for health delivery and fiscal autonomy, as LGAs cannot create new health revenue streams without central approval (Bofin & Tjernström, 2015). Lastly, weak monitoring frameworks mean health

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resources are often allocated without understanding their impact on patient outcomes, leading to a cycle of clinical inefficiency (CAG, 2024).

Tarime Town Council, situated in the Mara region near the Kenyan border, faces a unique health resource landscape. As a gateway for cross-border trade and mining, it has potential for revenue, yet the Council Strategic Plan (2021/22–2025/26) highlighted a critical deficit of human resources for health, where staff-to-patient ratios remain below national standards. While the council prioritizes other infrastructure like roads and school, the health development budget is often squeezed by high administrative costs and the unpredictability of central government health transfers (CAG, 2023; Tarime TC, 2024).

1.3 Statement of the Problem

1) Ideally, financial resource allocation in local government health facilities should ensure equitable, efficient, and timely distribution of resources to support quality health care services. This includes maintaining the World Health Organization's recommended doctor-to-population ratio of 1:10,000, nurse-to-population ratio of 1:1,500, and Tanzania's target of 15 hospital beds per 10,000 population to meet national health priorities and the Sustainable Development Goals (Ministry of Health, 2025; World Health Organization, 2023).
2) However, despite fiscal decentralization reforms, Tarime Town Council continues to face serious resource allocation challenges. In 2022, the Council recorded a doctor-to-population ratio of 1:42,000 and a nurse-to-population ratio of 1:3,500, while bed capacity remained at only 8.5 beds per 10,000 population in 2023. Moreover, only 68% of approved non-salary health funds were disbursed in 2024/2025, contributing to medicine stock-outs averaging 45 days annually and a maternal mortality ratio of 385 deaths per 100,000 live births, exceeding the national average of 304 deaths per 100,000 live births. These indicators reflect weaknesses in planning, budgeting, and financial management that compromise the quality and accessibility of health services (Ministry of Health, 2025; Tarime Town Council Health Report, 2024).
3) Therefore, there is a need to examine the mechanisms for financial resource allocation in health facilities in Tarime Town Council. The study seeks to identify institutional and financial challenges affecting resource allocation and generate evidence to improve planning, budgeting, accountability, and equitable distribution of health resources, thereby enhancing health service delivery and supporting the achievement of national health goals (Ministry of Health, 2025; PO-RALG, 2024).

1.3 Specific Objectives

1. To assess financial resource allocation both unconditional and own local resources revenues in quality of health service delivery.
2. To determine the distribution of human resources efficiency toward the quality of health service delivery.

LITERATURE REVIEW

2.1 Financial Resource Allocation and the Quality of Health Service Delivery

Ahmad et al. (2021), in a systematic review using meta-analysis on local government resource allocation, found that financial autonomy significantly improves health service efficiency by reducing bureaucratic bottlenecks in fund utilization. Their argument is grounded in the principle that decentralized fiscal authority allows local governments to make quicker and context-specific decisions without waiting for central approvals. This is particularly important because delays in decision-making often translate into delays in service delivery. In relation to Tarime Town Council, this study suggests that limited fiscal discretion may be a key factor restricting timely allocation and efficient use of health funds, there by weakening responsiveness in health service delivery systems. This study mainly relies on secondary data and meta-analytical synthesis, focusing on broad institutional comparisons rather than primary empirical evidence at the council level; it also largely adopts fiscal federalism theory.

Laryea and Amponsah (2022), using regression analysis on West African decentralized funding systems, found that increased financial decentralization led to a 15% improvement in project completion rates. Their findings demonstrated a measurable positive relationship between decentralization and implementation efficiency, meaning that when local authorities control resources, they are more likely to complete planned activities within set timelines. This is because accountability and decision-making are closer to implementation units. Applied to Tarime Town Council, the study implies that strengthening decentralized financial control could improve completion of health-related projects such as facility upgrades and staffing plans. However, the study is limited by its cross-country quantitative design which does not capture institutional and administrative dynamics within specific local government authorities, and it uses generalized econometric models.

Mzenzi (2021), through longitudinal qualitative analysis of Tanzanian local government authorities, found that reliance on conditional central government grants limits the flexibility of councils to respond to local priorities despite improvements in own-source revenue collection. The study highlighted a structural contradiction where

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councils appear financially supported but remain functionally constrained due to strict spending conditions attached to funds. This creates a situation where local needs cannot be fully addressed because funds are earmarked and not easily reallocated. In Tarime Town Council, this suggests that dependence on conditional funding such as Health Basket Funds may be restricting adaptive and need-based health service delivery. However, this study is largely qualitative and nationally generalized, focusing on broad fiscal behavior without isolating sector-specific health allocation mechanisms, and it is grounded in institutional constraint theory.

Mbogella et al. (2021), using multiple regression analysis on institutional performance and resource allocation, found that delayed release of health funds significantly reduces councils' absorption capacity, leading to inefficiencies in service delivery systems. The study explains that when funds arrive late, procurement processes are disrupted, implementation timelines are compressed, and planned health activities cannot be fully executed. This creates a ripple effect that weakens overall system performance. In Tarime Town Council, this finding implies that recurrent delays in fund disbursement may be directly contributing to disruptions in medicine procurement and overall service inefficiency. However, the study applies a purely quantitative regression model that does not explore administrative bottlenecks or governance processes behind delays.

Mrope (2025), using predictive modeling on local government health financing, found that councils receiving less than 70% of their allocated health budgets in the first two quarters experience a 40% higher probability of service delivery failure. The study demonstrates that timing of disbursement is as critical as the amount of funding because early financing determines the pace of implementation. Late or incomplete releases create cumulative operational inefficiencies across the health system. For Tarime Town Council, this suggests that irregular and delayed disbursement patterns may be increasing the likelihood of system breakdowns such as drug shortages and reduced clinical performance. However, the study was predictive and model-based, relying on hypothetical projections rather than empirical field-level verification, and it uses macro-level fiscal modeling.

2.4.2 Human Resource Distribution and the Quality of Health Service Delivery

Mrope (2017), in a study on procurement budgeting, found that staffing density is the most important determinant of health service performance, as it directly influences patient recovery rates. The study explained that human resources act as the active link between financial inputs and actual service delivery outcomes, meaning that even well-funded systems fail if staffing levels are inadequate. Similarly, the availability of skilled health workers determines whether health investments translate into real clinical impact. In relation to Tarime Town Council, this suggests that human resource shortages may be a major bottleneck preventing financial resources from being effectively converted into quality health services. However, the study is limited by its focus on procurement and budgeting efficiency using survey-based correlation analysis, without examining institutional staffing allocation mechanisms within decentralized local government health systems.

Njunwa (2022), in a study on human resource management and service delivery in Tanzania, found that staffing density significantly influences service delivery outcomes, with doctor-to-patient ratios strongly linked to recovery rates and service quality. The study highlighted that unequal distribution of health workers creates performance disparities across facilities, particularly between urban and rural areas. This suggests that staffing levels are not only a quantity issue but also a distributional challenge affecting equity in service delivery. In the context of Tarime Town Council, this implies that unequal staffing across facilities may be reducing the overall effectiveness of health service delivery. However, the study is based on survey and interview methods that capture perceptions rather than administrative allocation processes, and it applies a general HRM framework rather than a resource allocation mechanism framework used in this study.

KPMG Kenya (2021), through comparative performance audits, found that human capital accounts for approximately 70% of variation in health system performance across facilities. The study demonstrated that differences in staff competence, availability, and distribution explain most of the observed disparities in service quality and efficiency. This implies that financial investments alone are insufficient without adequate human capital deployment. For Tarime Town Council, this suggests that improving health outcomes requires prioritizing human resource planning alongside financial allocation. However, the study is audit-based and cross-country in nature, focusing on benchmarking rather than in-depth institutional analysis, and it does not explore local government allocation systems or decentralization dynamics, which this study investigates.

Mbogella (2021), using multiple regression analysis, found that inadequate skilled clinicians lead to underutilization of expensive medical equipment in health facilities. The study explained that even when infrastructure and equipment are available, lack of trained personnel prevents effective service delivery, resulting in inefficiency and wasted investment. This highlights the interdependence between human and physical resources in health systems. In Tarime Town Council, this suggests that shortages of skilled health workers may be contributing to inefficiencies in the use of available health infrastructure. However, the study is quantitatively

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focused on regression relationships without exploring administrative staffing allocation decisions within councils, and it applies a general institutional performance model rather than a health-sector-specific allocation framework. Ahmad (2021), in a systematic review, found that the availability of qualified health personnel is the strongest predictor of patient satisfaction in health service delivery systems. The study emphasized that technical competence, responsiveness, and availability of staff directly influence patients' perceptions of service quality. This suggests that human resources are not only operational inputs but also key determinants of user experience and trust in health systems. In Tarime Town Council, this implies that staffing shortages may be contributing to declining patient satisfaction and perceived service quality. However, the study relies on secondary data synthesis across multiple contexts and does not provide localized empirical evidence at council level, nor does it examine allocation mechanisms within decentralized Tanzanian health systems, which this study addresses.

3.0 METHODOLOGY

The study examining the effectiveness of government resource allocation on the quality of health service delivery in Tanzania Local Government Authorities, using Tarime Town Council as a case study, adopted a descriptive research design and a mixed-methods approach to collect both quantitative and qualitative data. The study was conducted in Bomani and Sabasaba wards of Tarime Town Council, involving a target sample of 389 respondents selected from key administrative officials, political leaders, Council Health Management Team members, health workers and community residents. Purposive sampling was used to select 20 key informants with relevant administrative and managerial experience, while simple random sampling was employed to select health workers and community members. Data were collected through structured questionnaires, semi-structured interviews and documentary reviews of relevant government reports, council strategic plans, health plans and policy documents. Quantitative data were analysed using the Statistical Package for Social Sciences (SPSS), applying descriptive and inferential statistical techniques, including frequencies, percentages, means, standard deviations, correlation analysis, Analysis of Variance (ANOVA) and linear regression analysis, while qualitative information was analysed thematically to identify recurring patterns and explanations. Out of the 389 targeted respondents, 369 successfully participated, representing a response rate of 94.9%. Furthermore, the study ensured validity and reliability through expert reviews, pilot testing and Cronbach's Alpha assessment. Ethical considerations were also observed through institutional research clearance, informed consent, confidentiality, anonymity and academic integrity. This methodological framework enabled the researcher to comprehensively examine how financial resource allocation, human resource distribution and resource allocation mechanisms influence the quality of health service delivery in Tarime Town Council.

4. RESEARCH FINDINGS

4.5 Influence of Financial Resource Allocation (Unconditional Grants and Own-Source Revenue) on the Quality of Health Service Delivery

The first specific objective examined the extent to which the combination of unconditional grants and own-source local revenue influences the quality of health service delivery in Tarime Town Council. Five Likert-scale statements were administered to the 369 respondents. The aggregated frequencies, percentages, means and standard deviations are presented in Table 4.5. Interpretation of the mean scores follows the scale: 1.00–1.80 (Very low / strongly disagreed), 1.81–2.60 (Low / Disagreed), 2.61–3.40 (Medium / Neutral), 3.41–4.20 (High / Agreed) and 4.21–5.00 (Very high / Strongly agreed).

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Table 4.1: Responses on Financial Resource Allocation

Statement	SD (1)	D (2)	N (3)	A (4)	SA (5)	Mean	Std. Dev.
1. The combination of Unconditional Grants and Own-Source revenue is sufficient to maintain a steady supply of essential medicines.	89 (24.1 %)	142 (38.5 %)	18 (4.9 %)	87 (23.6 %)	33 (8.9 %)	2.5474	1.2891
2. Local revenue is effectively used to fill the gaps when central government funds are delayed.	76 (20.6 %)	131 (35.5 %)	15 (4.1 %)	98 (26.6 %)	49 (13.3 %)	2.7642	1.3427
3. Financial resources are allocated equitably to ensure that health services are accessible to both town and border residents.	68 (18.4 %)	125 (33.9 %)	12 (3.3 %)	112 (30.4 %)	52 (14.1 %)	2.8770	1.3518
4. The council's health budget allows for the procurement of modern diagnostic equipment beyond basic clinical needs.	104 (28.2 %)	148 (40.1 %)	14 (3.8 %)	71 (19.2 %)	32 (8.7 %)	2.4011	1.2654
5. Increased local revenue collection has visibly improved the physical state of health facilities in Tarime.	71 (19.2 %)	119 (32.2 %)	16 (4.3 %)	109 (29.5 %)	54 (14.6 %)	2.8810	1.3672

Source: Field Data, (2026)

In relation to question number one, the results revealed that 89 (24.1%) respondents strongly disagreed, 142 with (38.5%) disagreed, 18 with (4.9%) remained neutral, 87 with (23.6%) agreed and 33 with (8.9%) strongly agreed that the combination of unconditional grants and own-source revenue is sufficient to maintain a steady supply of essential medicines. The respondents disagreed with a mean value of 2.5474 and a standard deviation of 1.2891. This indicates that the majority of respondents disagreed with the statement. The findings suggested that the current mix of central government transfers and locally generated funds is widely perceived as inadequate to guarantee a consistent availability of essential medicines in Tarime Town Council. Such a perception is consistent with the persistent stock-outs reported in local health facilities and points to structural weaknesses in the volume, timing and prioritisation of financial resources allocated to the health sector. This finding was similar to those of Kuwawenaruwa et al. (2024), who established that delayed fund disbursement and insufficient domestic financing remain major causes of essential medicine stock-outs in Tanzanian primary health facilities.

In relation to question number two, the analysis showed that 76 with (20.6%) respondents strongly disagreed, 131 (35.5%) disagreed, 15 with (4.1%) were neutral, 98 with (26.6%) agreed and 49 with (13.3%) strongly agreed that local revenue is effectively used to fill the gaps when central government funds are delayed. The respondents were neutral with A mean score of 2.7642 and a standard deviation of 1.3427 respectively. This denoted that respondents were largely undecided or only moderately convinced about the effectiveness of own-source revenue in bridging financing gaps. The result implied that although some local revenue is collected, it is not perceived as sufficiently flexible or adequately ring-fenced to cushion the negative effects of delayed central disbursements.

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Consequently, health facilities continue to experience operational interruptions during periods of late fund release, thereby affecting the continuity of service delivery. This finding was similar to those of ThinkWell (2024), who observed that own-source revenues in Tanzanian local governments remain too limited and inflexible to effectively cushion delays in intergovernmental transfers.

In relation to question number 3, the data indicated that 68 with (18.4%) respondents strongly disagreed, 125 with (33.9%) disagreed, 12 (3.3%) remained undecided, 112 with (30.4%) agreed and 52 with (14.1%) strongly agreed that financial resources are allocated equitably to ensure that health services are accessible to both town and border residents. The respondents were neutral with mean of 2.8770 and a standard deviation of 1.3518. The medium rating showed that respondents were neither strongly convinced nor completely dismissive of the equity of resource allocation. The findings therefore suggested that while some efforts towards balanced distribution exist, a substantial proportion of stakeholders still perceive uneven access to financial resources between the more central urban facilities and the border or peripheral wards of Tarime Town Council. This finding was similar to those of the World Bank (2025), which reported persistent geographical inequities in the allocation of health resources across Tanzanian local government authorities, particularly between urban centered and peripheral or border areas.

In relation to question number 4 the responses revealed that 104 with (28.2%) respondents strongly disagreed, 148 with (40.1%) disagreed, 14 (3.8%) were neutral, 71 with (19.2%) agreed and 32 with (8.7%) strongly agreed that the council's health budget allows for the procurement of modern diagnostic equipment beyond basic clinical needs. The respondents disagreed with mean 2.4011 and a standard deviation of 1.2654. The low mean clearly indicated that the majority of respondents disagreed with the statement. The result demonstrated that the existing health budget is regarded as insufficient to support investment in modern diagnostic technology. As a consequence, many facilities remain dependent on outdated equipment, which limits diagnostic accuracy and the overall quality of clinical care offered to patients in Tarime Town Council. This finding was similar to those of PO-RALG (2025), which noted that many Tanzanian councils continue to priorities basic operational expenditures over capital investments in modern diagnostic equipment due to constrained health budgets.

In relation to question number 5, the findings showed that 71 (19.2%) respondents strongly disagreed, 119 with (32.2%) disagreed, 16 with (4.3%) remained neutral, 109with (29.5%) agreed and 54 (14.6%) strongly agreed that increased local revenue collection has visibly improved the physical state of health facilities in Tarime. The respondents were neutral with a mean value of 2.8810 with a standard deviation of 1.3672. This medium rating suggested that respondents were only moderately convinced that growth in own-source revenue has produced visible infrastructural improvements. The perception points to possible weaknesses in the prioritisation, utilisation or monitoring of locally generated funds for the physical upgrading of health facilities within the council. This finding is similar to those of Kessy (2023), who found out that higher own-source revenue retention in Tanzanian local governments does not automatically translate into visible improvements in health facility infrastructure unless accompanied by strong prioritisation and accountability mechanisms.

Here is what the first respondent said

> ***"The formula-based system is the official one we are supposed to follow under FBBAS and DHFF. In practice, political pressure from councillors and ward leaders often overrides the formula. When a councillor wants a new dispensary or equipment in his ward before elections, the technical criteria are pushed aside. We still use the formula for the big central grants, but for own-source revenue and small adjustments, politics plays a big role".***

The response revealed a clear gap between the formal rules and actual practice in Tarime Town Council. Although the Formula-Based Budgetary Allocation System and DHFF are the official mechanisms, political influence frequently determines final decisions on smaller allocations and own-source revenue. This confirmed the literature that local resource allocation in Tanzanian LGAs is often shaped by political priorities rather than purely technical criteria. The dominance of political considerations can improve equity in some cases by directing resources to underserved border areas, but it also creates unpredictability and inconsistency. As a result, facilities in politically weak wards may receive fewer resources even when their patient load is higher. This mixed mechanism weakens the reliability of planning and reduces the overall effectiveness of resource allocation in supporting quality health services. The finding supported the need for a stronger technical safeguard within the existing legal framework. This finding was similar to those of Mtisho and Rutenge (2024), who examined political interference in Temeke Municipal Council, Tanzania, and found out that political influence significantly affects budgeting, budget allocation, revenue collection and expenditure, and social-service development. Their study showed that such interference can positively shape service delivery in some areas while creating inconsistencies and reducing technical objectivity, mirroring the gap between the official Formula-Based Budgetary Allocation System/DHFF

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rules and actual practice driven by councillors and ward leaders. This confirmed that political priorities frequently override technical criteria in Tanzanian LGAs, producing both occasional equity gains and unpredictability that weakens planning reliability.

Here is what respondent said

> ***"DHFF has helped a lot because money now goes straight to the facility account instead of waiting at the council. But the problem is that the central government still delays the release of the money into the DHFF accounts. Sometimes we wait two or three months. When the money finally arrives, the procurement process is rushed and we still face stock-outs of medicines".***

This response showed that DHFF has improved the flow of funds at the facility level by removing intermediate bureaucratic layers, which is a positive achievement of the reform. However, the persistence of delays at the central treasury level means that the full benefit of the mechanism has not been realized. The DMO's experience indicates that technical reforms alone are insufficient when the upstream disbursement system remains slow. The continued medicine stock-outs of approximately 45 days per year, as noted in the problem statement, are therefore partly explained by these residual delays. The finding demonstrated that the effectiveness of allocation mechanisms depends on the entire chain of fund release, not only on the final transfer to facilities. Strengthening the predictability of central transfers remains critical for improving service quality in Tarime Town Council. This finding was similar to those of Mshana et al. (2024), who investigated provider autonomy under Direct Facility Financing in Singida Region, Tanzania, and reported widespread delays in HBF/DHFF disbursements from the central Treasury that often spanned more than a quarter. Facilities consequently faced rushed procurement, incomplete budget execution, and medicine shortages even after funds reached facility accounts. The study underscored that technical reforms at the facility level remain incomplete when upstream central-release systems stay slow, exactly as observed in Tarime

4.3.2 Objective two: Distribution of Human Resources and the Quality of Health Service Delivery

The second objective assessed the distribution and adequacy of human resources. The responses of the 369 respondents was summarised in Table 4.6.

Table 4.6: Responses on Human Resource Distribution

	Statement	SD (1)	D (2)	N (3)	A (4)	SA (5)	Mean	Std. Dev.
1.	The current distribution of medical staff ensures that patients do not wait more than 30 minutes for consultation.	97 (26.3 %)	139 (37.7 %)	11 (3.0 %)	85 (23.0 %)	37 (10.0 %)	2.5271	1.2986
2.	Skilled medical professionals (doctors/specialists) are fairly distributed between urban centres and remote border wards.	112 (30.4 %)	141 (38.2 %)	13 (3.5 %)	72 (19.5 %)	31 (8.4 %)	2.3737	1.2479
3.	Human-resource levels are adequate to provide 24-hour emergency services without staff burnout.	108 (29.3 %)	145 (39.3 %)	14 (3.8 %)	68 (18.4 %)	34 (9.2 %)	2.3900	1.2613
4.	Regular clinical supervision and performance appraisals (OPRAS) have improved the responsiveness of frontline health workers.	54 (14.6 %)	89 (24.1 %)	17 (4.6 %)	138 (37.4 %)	71 (19.2 %)	3.2260	1.3621
5.	Staffing vacancies are filled promptly to prevent service interruptions in critical departments (e.g., Maternity, Lab).	119 (32.2 %)	136 (36.9 %)	12 (3.3 %)	70 (19.0 %)	32 (8.7 %)	2.3496	1.2684

Source: Field Data, (2026)

In relation to question number one, the results revealed that 97 (26.3%) respondents strongly disagreed, 139 with (37.7%) disagreed, 11 with (3.0%) remained neutral, 85 with (23.0%) agreed and 37 with (10.0%) strongly agreed that the current distribution of medical staff ensures that patients do not wait more than 30 minutes for consultation. The respondents disagreed with a mean value of 2.5271 and a standard deviation of 1.2986. This low mean, combined with the fact that 64.0% of respondents either disagreed or strongly disagreed, constitutes a strong finding that waiting times remain unacceptably long. The strong disagreement indicated that the present

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staffing pattern in Tarime Town Council is widely regarded as inadequate to guarantee prompt consultation, thereby reducing patient satisfaction and the overall efficiency of health service delivery.

This finding was similar to those of Njunwa (2022), who examined human resource management and service delivery in Tanzanian local government authorities. The study established that inadequate staffing density was strongly associated with prolonged patient waiting times and reduced service quality. Njunwa further observed that facilities with lower staff-to-patient ratios experienced significant delays in consultation, which negatively affected recovery rates and overall patient satisfaction. The research concluded that equitable and adequate distribution of health workers remains a critical determinant of timely service delivery in decentralized health systems.

In relation to question number two, the analysis showed that 112 (30.4%) respondents strongly disagreed, 141with (38.2%) disagreed, 13 with (3.5%) were neutral, 72 with (19.5%) agreed and 31 (8.4%) strongly agreed that skilled medical professionals (doctors and specialists) are fairly distributed between urban centres and remote border wards. The respondents disagreed with mean value of 2.3737 with a standard deviation of 1.2479. The strong finding was that 68.6% of respondents disagreed or strongly disagreed with the statement, producing one of the lowest means in the entire objective. This overwhelming rejection demonstrated clear perception of inequitable distribution of skilled health workers, with border and peripheral wards viewed as significantly understaffed compared with the more central urban facilities of Tarime Town Council. This finding was similar to that of the Ministry of Health (2025) in the Mid-Term Review of Human Resources for Health under the Health Sector Strategic Plan V. The review reported persistent urban–rural imbalances, with urban areas hosting a disproportionately higher share of skilled health workers while rural and border regions continue to face acute shortages. It further noted that more than half of available doctors are concentrated in urban centres, leaving remote facilities severely understaffed. The report emphasized that limited use of workload indicators and weak deployment mechanisms have perpetuated these inequities across Tanzanian local government authorities.

In relation to question number 3 , the data indicated that 108 (29.3%) respondents strongly disagreed, 145 (39.3%) disagreed, 14 with (3.8%) remained undecided, 68 with (18.4%) agreed and 34 (9.2%) strongly agreed that human-resource levels are adequate to provide 24-hour emergency services without staff burnout. The respondents disagreed with mean of 2.3900 and a standard deviation of 1.2613. The strong finding emerged from the fact that 68.6% of respondents disagreed or strongly disagreed with the claim. This majority rejection revealed that staffing levels are widely regarded as insufficient to sustain continuous emergency services without overworking the available personnel, thereby threatening both the quality of care and the well-being of health workers in Tarime Town Council. This finding was similar to those of Mbogella et al. (2021), who investigated resource allocation strategies and institutional performance in Tanzanian local government authorities. Their study found out that inadequate numbers of skilled clinicians led to excessive workloads, staff burnout and reduced capacity to maintain continuous emergency services. The authors further reported that understaffed facilities experienced higher rates of service interruption and declining staff morale. They concluded that sustainable emergency care depends heavily on maintaining adequate human resource levels relative to patient demand.

In relation to question number four, the responses revealed that 54 (14.6%) respondents strongly disagreed, 89 with (24.1%) disagreed, 17 with (4.6%) were neutral, 138 with (37.4%) agreed and 71 with (19.2%) strongly agreed that regular clinical supervision and performance appraisals (OPRAS) have improved the responsiveness of frontline health workers. The respondents were neutral with mean of 3.2260 and a standard deviation of 1.3621. Although the mean fell in the medium category, the strong finding was that 56.6% of respondents agreed or strongly agreed with the statement, making it the only item in this objective that attracted majority support. The result suggested that clinical supervision and the Open Performance Review and Appraisal System are beginning to yield positive effects on staff responsiveness, even if the overall impact remains moderate rather than high. This finding is similar to those of Kumburu et al. (2017), who examined the influence of human resource management practices on service delivery in Tanzanian local government authorities. Their research established that regular performance appraisal systems, including OPRAS, were positively associated with improved staff responsiveness and accountability. The study further noted that facilities where supervision and appraisal were consistently implemented recorded better service orientation among frontline workers. However, the authors cautioned that the benefits remain moderate when appraisal processes are not fully institutionalised or supported by adequate follow-up mechanisms.

In relation to question number five, the findings showed that 119 (32.2%) respondents strongly disagreed, 136 with (36.9%) disagreed, 12 with (3.3%) remained neutral, 70 with (19.0%) agreed and 32 (8.7%) strongly agreed that staffing vacancies are filled promptly to prevent service interruptions in critical departments such as Maternity and the Laboratory. The respondents disagreed with mean value of 2.3496 with a standard deviation of 1.2684. The strong finding is particularly evident here, as 69.1% of respondents either disagreed or strongly disagreed

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with the statement, producing the lowest mean among all five human-resource items. This overwhelming disagreement demonstrated that delays in filling vacancies remain a serious and widely recognised problem, leading to frequent service interruptions in critical departments and undermining the continuity of essential health services in Tarime Town Council. This finding was similar to those of the World Bank (2025), which analysed human resources for health challenges in Tanzania and other East African countries. The report highlighted that cumbersome recruitment and replacement procedures continue to delay the filling of vacant positions in critical service areas such as maternity and laboratory departments. It further observed that these delays contribute to service interruptions and reduced continuity of care, particularly at the primary health care level. The study concluded that streamlining recruitment processes remains essential for maintaining uninterrupted essential health services in local government facilities.

Here is what respondent said:

> ***"Wards has many people and is farther from the main hospital. The formula does not fully capture our high population pressure and the distance patients travel. We receive the standard allocation, but it is not enough. Sometimes political leaders help us get extra funds, but it is irregular. Patients wait longer and medicines finish faster".***

This response reveals that the existing allocation mechanism does not adequately address the specific demographic and geographical realities of denser residential wards such as Sabasaba. The formula seemed to under-weight population pressure and distance from higher-level facilities. As a result, the ward experiences longer waiting times and more frequent medicine stock-outs. Occasional political interventions provide temporary relief but create inconsistency rather than systematic equity. The finding showed that a purely technical formula that does not incorporate real-time local data can fail to support quality service delivery in high-need areas. Adjusting the allocation criteria to better reflect population density and accessibility would make the mechanism more responsive and effective in improving health outcomes in wards. This finding was similar to those of Rugeiyamu (2025), who showed that formula-based and equalisation transfers in Tanzania often fail to reflect real differences in population pressure, revenue capacity, geography, and local needs, producing uneven development. Standard allocations therefore leave high-density or distant wards under-resourced, resulting in longer waiting times and faster medicine stock-outs; occasional irregular political top-ups only add inconsistency rather than systematic correction.

Here is what respondent said:

> ***"Transparency has improved because money comes through GePG and we can see the amount on the facility account. Leakage at the council level has reduced. But delays still happen, and when money arrives late, we are forced to buy in a hurry, sometimes at higher prices. The system is better than before, but it is not yet perfect".***

The facility in-charge confirmed that digital tools such as GePG and the direct transfer under DHFF have increased transparency and reduced opportunities for leakage at the council level. This is a significant improvement in the accountability of the allocation mechanism. However, the persistence of delayed releases continues to create practical inefficiencies, including rushed procurement and higher costs. The overall picture was one of partial success: the technical design of the mechanism has strengthened transparency, yet operational bottlenecks in timing still undermine its full effectiveness. For quality health service delivery to improve consistently, both the transparency gains and the remaining timing problems must be addressed. The finding supported the argument that modern allocation mechanisms work best when supported by predictable and timely fund releases from the centre. This finding was similar to those of Tani et al. (2025) and Mwaisengela (2025), who evaluated DHFF implementation across Tanzanian primary facilities and found out that direct transfers and digital tracking (including systems comparable to GePG) improved transparency and reduced council-level leakage, yet persistent central delays forced rushed procurement and higher costs. The reforms deliver partial success in accountability while operational timing bottlenecks continue to limit overall effectiveness for quality service delivery.

5. SUMMARY, CONCLUSION AND RECOMMENDATION

5.2 Summary of Findings

5.1 Summary

The findings on the first objective, which examined the influence of financial resource allocation through unconditional government grants and own-source revenue on the quality of health service delivery, revealed that the available financial resources were generally inadequate to support reliable health services in Tarime Town Council. Specifically, 62.6% of respondents disagreed or strongly disagreed that the combination of unconditional grants and own-source revenue was sufficient to maintain a steady supply of essential medicines, with a mean score of 2.5474 and a standard deviation of 1.2891. Similarly, 56.1% disagreed that locally generated revenue was

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effectively used to fill financial gaps when central government funds were delayed, although the mean score of 2.7642 indicated a moderate assessment. Regarding equitable allocation, 52.3% disagreed that financial resources were distributed fairly to ensure access to health services for both town and border residents, with a mean score of 2.8770. Furthermore, 68.3% disagreed that the Council's health budget was sufficient to support the procurement of modern diagnostic equipment beyond basic clinical requirements, recording a mean score of 2.4011. In addition, 51.4% disagreed that increased local revenue collection had visibly improved the physical condition of health facilities, with a mean score of 2.8810. Overall, these findings demonstrate that financial resource allocation in Tarime Town Council faces challenges relating to the adequacy, timeliness, equity and prioritisation of available funds, which consequently affect the consistent availability of medicines, modern diagnostic equipment and improvements in health infrastructure.

Furthermore, the findings on the second objective, which examined the distribution of human resources and the quality of health service delivery, established that health facilities in Tarime Town Council experience inadequate and unequal distribution of health workers. The results indicated that 64.0% of respondents disagreed or strongly disagreed that the current distribution of medical staff ensures that patients wait for less than thirty minutes before receiving consultation, with a mean score of 2.5271 and a standard deviation of 1.2986. Likewise, 68.6% disagreed that skilled medical professionals, including doctors and specialists, were fairly distributed between urban centres and remote border wards, recording a mean score of 2.3737. In addition, 68.6% disagreed that the available human resources were adequate to provide 24-hour emergency services without causing staff burnout, with a mean score of 2.3900. The findings also showed that 56.6% agreed or strongly agreed that regular clinical supervision and performance appraisals through the OPRAS system had improved the responsiveness of frontline health workers, although the mean score of 3.2260 reflected a moderate assessment. Moreover, 69.1% disagreed that staffing vacancies were filled promptly to prevent service interruptions in critical departments such as maternity and laboratory services, with a mean score of 2.3496. Collectively, the findings indicate that inadequate staffing levels, unequal deployment of skilled professionals, prolonged recruitment processes and excessive workloads remain important challenges affecting the quality and continuity of health service delivery in Tarime Town Council.

5.3 Conclusion

With respect to the first objective, the study concludes that the existing combination of unconditional government grants and own-source revenue is insufficient to support effective and reliable health service delivery in Tarime Town Council. The inadequacy and delays in the availability of financial resources, together with weaknesses in equitable distribution and prioritisation, have affected the consistent supply of essential medicines, procurement of modern diagnostic equipment and improvement of health facility infrastructure. Therefore, improving the quality of health services requires adequate, predictable and timely financial resources, supported by appropriate prioritisation of health facility needs.

Regarding the second objective, the study concludes that the distribution of human resources in health facilities within Tarime Town Council is inadequate and inequitable, particularly between urban centres and remote border wards. The shortage of skilled health professionals contributes to prolonged patient waiting times, excessive workloads, staff burnout and interruptions in critical services such as maternity, laboratory and emergency care. Although clinical supervision and performance appraisal practices have contributed to some improvement in the responsiveness of frontline health workers, these measures cannot fully address the challenges associated with insufficient staffing and delayed filling of vacancies. Consequently, equitable deployment and timely recruitment of qualified health workers are essential for improving the quality, accessibility and continuity of health service delivery.

5.4 Recommendations

Based on the findings and conclusions of the first and second objectives, the study proposes the following recommendations:

1. Strengthening financial resource allocation for health services: The Central Government, through the Ministry of Finance and PO-RALG, should ensure timely disbursement of approved health funds so that at least 80% of the approved non-salary health budget reaches health facilities within the first six months of every financial year. Furthermore, Tarime Town Council should allocate a fixed proportion of its own-source revenue, particularly revenue collected from border and mining activities, to the procurement of essential medicines, modern diagnostic equipment and improvement of health facility infrastructure. The Council should conduct quarterly financial monitoring to ensure that allocated funds are properly utilised and directed towards priority health service needs.
2. Improving the distribution and availability of qualified health workers: The Ministry of Health and PO-RALG, in collaboration with Tarime Town Council, should ensure that health workers are distributed according to patient numbers, workload and geographical needs, with priority given to remote border wards and highly populated communities. Vacant positions in critical departments, particularly maternity, laboratory and emergency services,

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should be identified and filled within three months of approval of recruitment opportunities. Additionally, the Council should strengthen regular clinical supervision and ensure that the OPRAS performance appraisal system is implemented consistently to improve staff responsiveness, accountability and the quality of health services

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