# AN ASSESSMENT OF DECENTRALISATION EFFECTIVENESS ON PUBLIC HEALTH SERVICE DELIVERY IN RURAL TANZANIA: A CASE STUDY OF PANGANI AND URAMBO LOCAL GOVERNMENT AUTHORITIES

**LUFUNYO HUSSEIN**

**A THESIS SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY (PhD) IN PUBLIC ADMINISTRATION OF THE OPEN UNIVERSITY OF TANZANIA**

**2017**

## CERTIFICATION

The undersigned certifies that has read and hereby recommends for acceptance of a thesis entitled **An Assessment of Decentralisation Effectiveness on Public Health Service Delivery in Rural Tanzania: A Case study of Pangani and Urambo Local Government Authorities** in fulfilment of the requirement for the Degree of Doctor of Philosophy (PhD) of The Open University of Tanzania.

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**Dr. William A. Pallangyo**

**(Supervisor)**

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**Date**

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## DECLARATION

**I Lufunyo Hussein,** do hereby declare that this thesis is my own original work and that it has not been presented or produced and will not be presented to any other University for similar or any other degree award.

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Signature

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Date

## DEDICATION

This work is dedicated to my beloved mother, the late Uria Israel Kitossi and the late father Saimon Hussein Mpumilwa whose endless efforts and support for my education and academic achievements made possible this historic achievement in my in life.

## ACKNOWLEDGEMENT

The completion and success of this work is a result of contributions and cooperation by many people and institutions. It is not possible to mention everyone involved in the realisation of this work with his or her contributions, but I thank them all. Above all glory is to God Almighty who protected and guided me in making my dream a reality. Sincere thanks are due to my supervisor Dr. William A. Pallangyo, for his critical and constructive guidance, directives and contributions towards the success of this work. As an exemplary teacher and supervisor, since he accepted to supervise this work he has been my mentor, role model and inspiration. His comments, advice and panel beating from the proposal writing to submission stage moulded my academic competency and the outcome of this work.

Mr. Said H. Nassor, former Chief Executive Officer (CEO) of Tanzania Public Service College (TPSC) and Dr. Henry Mambo incumbent CEO for their encouragement and advice. I humbly thank them for granting me with a permission, sponsoring my study and providing the needed financial and other resources. I understand, without such support, I would not have been able to produce this work as it is today. The entire Management, academic and none academic staff of Tanzania Public Service College (TPSC) also provided moral and silent material support for this study. Special thanks are due to the Community of the Open University of Tanzania for creating a harmonious and supportive learning environment throughout my studies.

My heartfelt thanks must go to my wife Sarah Komba, my sons Joshua (Billbright)

and Josia (Jojo). They were tolerant when I left them alone as I struggled with fieldwork. I believe without their consent psychologically I could not do much. Despite all assistance, I received, all errors, omissions and shortfalls in this study output, remains my sole responsibility.

## ABSTRACT

This study aimed to assess the Effectiveness of Decentralisation on the delivery of Public Health Services in rural Tanzania drawing experiences from Pangani and Urambo Local Government Authorities (LGAs). The study adopted a case study design and employed mainly qualitative approach to address the problem. The study used mixed data collection methods and technique, analysis was mainly qualitative. The study established that; for the past fifteen years decentralisation had decimal effects on improving Public Health Service Delivery in Rural Tanzania. Institutional characteristics and legal frameworks posed hindrances for full fruition of intended effectiveness of decentralisation on health service delivery in rural Tanzania. With decentralisation, health services were characterised by a number of shortcomings that affected access and quality. The establishment of health centres and supply of needed equipments, drugs and medicines, health workers, distance, complaints handling mechanisms and responsiveness remained as problems. Delayed service provision, poor time management by staff, minimal accountability and transparency, minimal political will, poor records management, shortage of health workers and resistance to change characterised public health service, remained so, and persisted. The study recommends a review and re alignment of the legal frame, administrative systems, structures and processes. Improvement on human resource for health and integration of decentralisation with other sector reforms is a crucial. There is also need for increased leadership commitment and political will, timely resource allocation, public awareness building and having home grown reforms and involvement of Local Government Authorities also recommended.

## TABLE OF CONTENTS

## LIST OF TABLES

## LIST OF FIGURES

## LIST OF ABBREVIATIONS

| | |
|---|---|
| ALAT | Association of Local Government Authorities in Tanzania |
| CBOs | Community Based Organisations |
| CCHP | Comprehensive Council Health Plan |
| CHMT | Council Health Management Team |
| CHSB | Council Health Service Boards |
| CSCs | Client Service Charters |
| CSRP | Civil Service Reform Programme |
| D by D | Decentralisation by Devolution |
| DED | District Executive Director |
| DFCM | District Full Council Meeting |
| DH | District Hospital |
| DMO | District Medical Officer |
| FGD | Focus Group Discussion |
| FSRP | Financial Sector Reform Programme |
| HC | Health Centres |
| HFC | Health Facility Committee |
| HIV | Human Immunodeficiency Virus |
| HSPOW | Health Sector Programme of Work |
| HSRs | Health Sector Reforms |
| HSSP | Health Sector Strategic Plan |
| IHI | Ifakara Health Institute |
| JICA | Japanese International Cooperation Agency |
| LGAs | Local Government Authorities |

| | |
|---|---|
| LGRP | Local Government Reform Program |
| LSRP | Legal Sector Reform Programme |
| MCH | Maternal and Child Health |
| MDGs | Millennium Development Goals |
| MoHSW | Ministry of Health and Social Welfare |
| MSD | Medical Stores Department |
| NGOs | Non-Governmental Organisations |
| NPM | New Public Management |
| O&OD | Opportunities and Obstacles to Development |
| OECD | Organization of Economic Cooperation Development |
| PHC | Primary Health Care |
| PHSD | Public Health Service Delivery |
| PMO-RALG | Prime Ministers' Office–Regional Administration and Local Government Administration |
| PSRP | Public Service Reform Programme |
| RH | Regional Hospital |
| SARA | Service Availability Readiness Assessment |
| SPSS | Statistical Program for Social Sciences |
| TBAs | Traditional Birth Attendants |
| TGPRS | Tanzania Government Poverty Reduction Strategy |
| TPSC | Tanzania Public Service College |
| TShs | Tanzanian Shillings |
| UNDP | United Nations Development Program |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |

| | |
|---|---|
| UNICEF | United Nations Children's Fund |
| URT | United Republic of Tanzania |
| VEO | Village Executive Officer |
| WB | World Bank |
| WDC | Ward Development Committee |
| WDC | Ward Development Committee |
| WEO | Ward Executive Officer |
| WHCs | Ward Health Committees |
| WHO | World Health Organization |

# CHAPTER ONE

# 1.0 INTRODUCTION AND BACKGROUND

## 1.1 Introduction

This study assessed the effectiveness of decentralisation on public health Service delivery (PHSD) in rural Tanzania. The principal focus was to assess the extent to which Decentralisation of government functions from central government to grass root levels affected access and quality of public health service delivery in rural Tanzania. Experiences from Pangani and Urambo Local Government Authorities (LGAs) were drawn. The thesis was built on the existing debate on the impact of decentralization and service delivery in Local Government Authorities in rural Tanzania. Guided by institutional and principal agency theories, the thesis adopted qualitative approach to assess the effectiveness of decentralisation on Public Health service delivery in LGAs. In addressing the research question, the thesis employed the case study design and used interviews, documentary reviews, questionnaires, focus group discussions (FGDs) and observation methods.

Theoretically, decentralization is the process of devolving government functions to locals in order to improve access and quality of services delivery to the people by delegating power to Local Government Authorities (LGAs). The assumption is centred on the fact LGAs have the most relevant information on the people's local needs and preferences. Further more decentralisation was expected to improve service responsiveness, enhance public participation, accountability of public officials at the local level and improve service delivery (Kessy and Mc Court, 2010;

Rider, 2011, Noiset and Rider, 2011, Nyamuhanga *et al.*, 2013 and Hope, 2015).

The practical side of decentralisation indicates mixed results on the expected outcomes on the effectiveness of decentralisation on public service delivery (Gilson *et al*, 1994; Conyers, 2007; World Bank, 2008 and Robinson, 2007). The outcomes of decentralisation largely depend on institutional arrangements and characteristics, power relations, and on the coherences of decentralisation policies in specific context.

### 1.2 Background to the Problem

Implementation of decentralisation and public health service delivery in developed and developing nations have been strategically through frameworks of new public management and institutional approaches (Batley, 2004; Larbi, 2005, Masanyiwa et al, 2013 and Bossert, 2015). The idea of decentralisation was linked to subsidiary principle, which connotes that, what can be done efficiently and effectively at the lowest level of government should be done at that level and not at higher levels (Isaac, 2000 and World Bank, 2004). The World Bank Report argued that because people affecting decisions take place in local constituencies, citizens have more control over those decisions and this reflects their preferences (World Bank, 2004). Public health service delivery under the frameworks of decentralisation and local government reforms receives remarkable importance in development research, policy and academic discourse (Olowu, 2003); Andrews and de Vries, (2007) and Boex and Yilmaz (2010). Hope (2001) pointed out that, decentralisation is a means and vehicle through which governments are able to provide high quality service that

citizen need and value. Increased autonomy, particularly through reduced central administrative controls, allows sub national governments to design services commensurate to the needs of the people at grass root levels.

The World Bank (2004) pointed out that "decentralisation must reach the local clinic, the classroom and local water utilities in ways that create opportunities for strengthening accountability. The principle is that, in a decentralized system, public services will be more accessible and responsive to local needs because citizens directly or indirectly influence decisions about service design, resource allocation and service delivery (Hope, 2001 and Bossert, 2015).

Africa as part of the global community was taken also on board by these initiatives (Herrera and Post, 2014). At least more than half of African countries have decentralised their political, fiscal and administrative functions from the central to the local level, with high and increasing hopes of responding efficiently to the demands of the local electorate (World Bank, 2011; Yilmaz, 2009). Foquet (2014) also noted that, African countries took deliberate initiatives to reform their Public services with a key agenda of improving service delivery to the citizens through decentralising roles and responsibilities to Local Government Authorities.

Yet, despite these policy reform initiatives, contrasting outcomes of decentralisation are being witnessed between and within countries, with marked divergence in anticipated outcomes related to public services. Several studies underscore the positive impact of decentralisation (Faguet, 2012; Albornoz-Crespo & Cabrales,

2013) while others show its detrimental effect (Treisman, 2006) and even some show no effect at all (Khaleghian, 2003) or mixed evidence (Smith & Revell, 2016).

Health sector reforms and decentralisation was part of the most critical agenda of many nations intending to strengthen local governments in meeting the challenges of 21st Century on health service delivery. Decentralisation was pursued as one of the solutions to address challenges on public health service delivery in rural areas (Herrera and Post, 2014). This initiative attracted a serious theoretical and practical debate regarding the effectiveness of decentralisation on public health service delivery.

The public service reforms initiatives of the 1990s in Tanzania were a response to the deteriorated public services and consequent loss of confidence by the public on competence and integrity of public institutions to serve the nation (URT, 2000 and Venugopal and Yilmaz, 2010). Among the factors that attributed to this anomaly included: expansion of public service structures, pervasive political interference and patronage influence, lowly paid bureaucracy, red tape in decision making, nepotism and non responsive bureaucracy, violation of laws and human rights and dignity (Mushi, 2002; Mollel, 2010 and Venugopal and Yilmaz, 2010; Ringo *et al.*, 2013).

As a result, found it prudent the government to rethink and redefine its role, scope of functions, to review its structure and redefine the size of the public sector in addressing the needs and expectations of the predominantly rural society where majority live. In order to achieve these objectives the government undertook reforms that included the Civil Service Reform Program (CSRP) of 1990s. The overall

objective was to have a smaller, affordable, efficient, responsive and effectively performing public service. This initiative intended to foster development and sustained economy through improved service delivery and improved social welfare in the country (URT, 2000).

Mutahaba and Kiragu (2002) point out that, the thrust of those reforms was to restructure and overhaul the machinery of government, to regain control over the payroll and size of the establishment, to ensure cost containment and to retrench surplus staff. The assumption was that the new structures would lead to improved public service delivery such as in education, health, clean and safe water supply, roads and security services and hence improved welfare of the citizens (Pallotti, 2008).

Given the limited quality of public service delivery under the then Civil Service Reform, the Government launched an ambitious Public sector reform which included Public Service Reform Program (PSRP), Legal Sector Reform (LSRP), Financial Sector Reform (FSRP), Local Government Reform (LGRP), Health Sector Reforms (HSRP) and other related sector reforms (URT, 2000 and 2007).

Local Government Reforms in Tanzania as part of the broader Public Sector Reform Program, aimed to restructure local government authorities so that they can respond more effectively to local priorities of service delivery in a sustainable manner. The Local Government reforms initiatives started in 1996 following the publication of the Local Government Reform Agenda 1996-2000 that set the vision for the reforms

(URT, 1996 and 2007). The vision states clearly that the raison d'être for the devolution of government roles and authority is to enhance the capacity and efficiency of local government in delivering services to the people at local levels (URT, 1996).

In 1998, the government endorsed the policy of '...decentralisation by devolution...' through the Policy Paper on Local Government Reform to serve as the guiding framework for local government reforms in the country. The Policy paper spelt out clearly that public service provision be brought as close as possible to the users and shall reflect the people's demands, needs and priorities. It explains that the subsidiary principle involves decentralisation of public service provision linked to devolution of political powers to lower levels as feasible as possible (URT, 1998).

Local Government Reforms (LGR) under decentralisation also intended to enhance governance and to devolve powers to the grass root in order to improve provision and access to basic social and other services (REPOA, 2010). This study however focuses on the effectiveness of Decentralisation on Public Health Service Delivery (PHSD) in rural Tanzania. Health sector was one of the pioneer areas of decentralized service delivery through health sector reforms (HSRs). This initiative started in the 1990s and aimed at improving health services in rural communities (URT, 2003 and 2007). According to the National Health Policy, which guided the Health Sector Reforms, Local Government Authorities (LGAs) are responsible for running district hospitals, health centres at ward levels and dispensaries at village levels through subventions from central government and locally generated resources

(URT, 2003).

Decentralisation in Tanzania as a service delivery model and process, involved the transfer of the fiscal, administrative and political authority from the central government to local governments. It is viewed as a strategy inter alia for improving access, equity, quantity and quality of health services in rural areas (Kessy and Mc Court, 2010; Rider, 2011; Noiset and Rider, 2011; Nyamuhanga *et al.*, 2013; and Hope, 2015).

Decentralisation and health sector reforms were meant to transfer administration and management of health facilities and services from the Ministry of Health and Social Welfare (MoHSW) to Local Government Authorities (Munishi, 2003; URT, 2003, 2007; Mamdani and Bangser, 2004; Mubyazi *et al.*, 2004; Boon, 2007 and Masanyiwa, 2014). The National Health Policy provides that health services at Local Government Levels have to be devolved with a view to increase their mandate in health services provision in terms of coverage, accessibility, availability, responsiveness and quality (URT, 2003 and 2007).

Decentralisation as one of the most important components and strategy of health sector reforms aimed at transferring the key functions, responsibilities, power and resources from the central government to the local government authorities, as well as strengthening the capacity of local authorities. In adopting decentralisation as a strategy, LGAs were expected to operate largely as autonomous institutions and free to make policy and operational decisions consistent with the country's laws, policies

and institutions that have the power to possess both human and financial resources (Kessy and Mc Court, 2010; Rider, 2011; and Nyamuhanga *et al.*, 2013).

The expectations of decentralisation was premised on the assumption that it would yield, among other outputs, the delivery of reliable, accessible and quality services, including health services (URT, 2005 and Noiset and Rider, 2011). However, since the onset of decentralisation in the late 1990s and early 2000s particularly in the health sector, studies indicate that little has been documented on the effectiveness of the decentralisation in relation to health service delivery in rural Tanzania.

In her efforts to reform the health sector in line with decentralisation, Tanzania like any other developing nation fits into the global picture and African scenario with regard to reforms and specifically decentralisation and public health service delivery. The country adopted and implemented decentralisation as part of the broad reforms aimed at enhancing availability, quality, accessibility and equitable delivery of public health services rendered by LGAs (URT, 2003 and 2007). Tanzania's experience and long history in contextualising and implementing decentralisation of public health service delivery builds a justifiable case for making an assessment and analysing the effectiveness of decentralisation on public health service delivery.

### 1.3 Statement of the Problem

Despite the efforts to reform, the health sector under the decentralisation initiatives public health service delivery and its status in rural Tanzania remains a topical issue. From independence in 1961 to date health issues have continuously and consistently

recorded high premium as a priority sector (URT, 2015). For example, the National Health Policy point out clearly that decentralisation on health was implemented with the initial objective and expectations mainly to improve public health service delivery (URT, 2003 and 2007). It further states that decentralisation of health services provision aimed at improving delivery in terms of accessibility, equity, quantity, affordability, and reliability (URT, 2003 and 2007).

In addition, it aimed at transforming Local Government Authorities to be responsive to the local needs related to public health services and other services to the citizens. The National Health Policy points out clearly that decentralisation of public health service aimed at improving public health service delivery in Tanzania in terms of coverage, reliability, accessibility, availability of medicines and medical equipments, availability of required human resources, reduced distances and affordability (URT, 2003 and 2007).

Similarly all the National Health Sector Strategic Plans (HSSP I 1999-2004, HSSP II 2005-2009, and HSSP III 2009-2015) aimed at ensuring access and quality in terms of availability of medical supplies, human resource for health, reduced distance to health facilities and effective management of health services (URT, 2007 and 2009). The policy further provides that every Ward should have a Health Centre (HC) and villages should have a Dispensary with consistent and assured supply of essential drugs, medical kits and supplies as well as qualified personnel to ensure access and quality of public health services not denied (URT, 2003 and 2007). The achievements on these parameters would entail improved public health service delivery.

Despite the theoretical supportive and disputed arguments on the outcome of decentralisation in general terms, there is limited empirical evidence based on comprehensive assessment on how decentralisation has affected public health services delivery in rural Tanzania. Specifically, through a review of parliamentary sessions, (Hansard) and health sector performance reports, service users seem discontented on coverage and distribution of health services to meet the users' expectations (URT, 2007; 2009; 2013 and 2015). There is little evidence to substantiate and support the effectiveness of decentralisation in relation to public health service delivery. Such state of affairs demand answers on the effectiveness of decentralisation in relation to public health service delivery in rural Tanzania. In this regard, there is sound justification and is an issue that calls for an intensive study in this area. The study therefore intended to bridge this knowledge gap by providing empirical evidence on the effectiveness of decentralisation on service delivery and specifically public health services in rural Tanzania drawing experiences of Pangani and Urambo Local Government Authorities.

## 1.4 Objectives of the study

### 1.4.1 General Objective

The general objective of this study was to assess the effectiveness of decentralisation on public health service delivery in rural Tanzania.

### 1.4.2 Specific objectives

In order to address the main objective, the study had three specific research objectives, namely:

i) To examine the extent to which institutional characteristics affect decentralisation for improved public health service delivery in rural Tanzania.

ii) To determine the status of public health service delivery as a result of decentralisation in rural Tanzania

iii) To identify and analyse the challenges affecting decentralisation for improved public health service delivery in rural Tanzania.

## 1.5 Research questions

The study aimed to answer three research questions;

i) How do the institutional characteristics affect decentralisation for improved public health service delivery in rural Tanzania?

ii) To what extent has decentralisation affected public health service delivery in rural Tanzania?

iii) What challenges constrain implementation of decentralisation for improved public health service delivery in rural Tanzania?

## 1.6 Significance of the Study

This study assessed the effectiveness of decentralisation on public health service delivery (PHSD) in rural Tanzania. Three specific objectives underscored using two LGAs (Urambo and Pangani). Most of the studies so far undertaken on decentralisation have focused on administrative, political and financial aspects. Little had been documented on the effectiveness of decentralisation focusing on the thematic area at the lowest levels of LGAs in Tanzania. In this regard, a glaring gap was obvious and needed to be filled by a study of this type in order to contribute to

scholarly and empirical debate regarding decentralisation and public health service delivery. This study partly was also inspired by the efforts of the government to advocate and implement decentralisation in relation to seeing efficient and effective public health service delivery amidst the quest for poverty reduction in the country. The majority of Tanzanians particularly in the rural areas see health as a crucial contributor to their effective participation in social and economic activities.

The study in terms of methodology, the choice of only one service among many social services to be studied has been able to clearly elucidate the parameters of measuring public health service delivery in a thoroughly manner unlike other studies, which combined several issues. In so doing, the study profoundly contributes new knowledge on the theoretical and empirical literature about decentralisation and public health service delivery.

The timing of the study is in tandem with Tanzania being part of the United Nations Community and partly to implementation of Millennium Development Goals (MDGs) whereas one of the far arching goal was the quest to improve health service delivery at all levels.

In addition, Tanzania had just finished implementing the last phase of the broad Public Service Reforms (PSRs) and was on the verge of the implementing the last phase of Local Government Reforms (LGRP II) with decentralisation as a strategy to improve service delivery including public health services.

Therefore, the study aims to provide an explanation about the disappointing health service management and delivery in the country. In addition, the study aims to provide information to policy makers regarding the successes and challenges of decentralisation and health sector reforms in the country for future improved development policy consideration.

The study further envisaged to contribute towards an understanding of decentralisation conceptualisation in theoretical perspectives and its relation to public service delivery. The study premised to establish the institutional characteristics and the role of principals and agents in relation to decentralisation and public health service delivery in rural Tanzania.

Additionally, the study is a revelation to policy makers hence carefully and critically consider adopting reforms that aim to improve service delivery especially those, which directly touch on the lives of the people. Finally, in addition to helping to build my career, the study adds to already existing empirical and theoretical body of knowledge in terms of new insights about the ongoing public service sector reforms in Tanzania.

### 1.7 Delimitation of the Study

The study focused on decentralisation and its effectiveness on Public health service delivery in rural Tanzania using Pangani and Urambo LGAs in Tanga and Tabora Regions. The selected cases for the study were among the government organizational structural levels that have implemented decentralisation reforms and affected by the

policy actions since 2000.

In addition, Pangani and Urambo Local Authorities have similar institutional characteristics and organisational set up as any other Local Authority in the country, which was established by Act Number 7 of 1982 and as amended by Parliament Act Number 13 of 2006. The LGAs draw their mandate from the Constitution of the United Republic of Tanzania and Act number 7 of 1982. Furthermore, the two LGAs have devolved powers and responsibilities to lower tiers in line with the basic principles of decentralisation.

The study intended to assess whether decentralisation has resulted in outcomes that meet the expectations of the policy and the public (citizens) in response to the decentralisation policy objective of improving public health service delivery in terms of access, quantity, quality and its sub sequent management.

### 1.8 Limitations of the Study

The study involved dealing with politicians (Councillors, Village Chairpersons). At the time of data collection, the politicians were busy engaged with election campaigns for 2015 general election. Consequently, it was not easy to get hold of them for the planned interviews.

There was also the geographical problem of accessibility of some parts selected for the study. For instance, some wards and villages in Pangani required the use of local boats to reach them in the Indian Ocean and some were located on the banks River Pangani. This resulted in delays in pertinent data collection.

Financial limitations and time constraints also forced data collection to be limited to only two LGAs. It was the wish of the study-to-study many LGAs. However, the sampled LGAs have characteristics similar to all the other LGAs in terms of establishment, structure, mandate and all were expected to implement decentralisation intended to improve public health service delivery. Therefore, drawing a sample from only two Local Authorities (Pangani and Urambo LGAs) was considered adequate to draw representative conclusions on the effectiveness of decentralisation on the delivery public health services in Tanzanian's Local Authorities. The choice of methodology and data collection techniques designed to use primary and secondary information merits the planned conclusions drawn from the sampled LGAs. Thus, the findings and conclusions do paint a picture of the actual situation on the ground regarding the effectiveness of decentralisation on public health service delivery and other services in Tanzania as a whole.

The study believes and has a conviction that the issues raised would provoke further investigations by other academics with interest in the thematic area and other sector specific issues.

## 1.9 Definition of concepts

### 1.9.1 Public Sector

Bovaird (2005) defined Public Sector as part of the economy concerned with providing government services funded from public resources. The composition of the public sector in the context of Tanzania includes Government Ministries,

Independent departments, Government Agencies, Local Authorities and Parastatal organisations.

### 1.9.2 Local government

Local government that is that level of government that is closer to the people and therefore responsible for serving the development needs of the people and communities in specific local areas. Such an area could be a rural setting or urban setting, a village, a town, a suburb in a city or a city irrespective of size (URT, 2000). The constitution of the United Republic of Tanzania (1977) recognizes and provides for the decentralisation of local government system in Tanzania. Article 145 (1) established local government authorities in each region, district, urban area and village in the United Republic of Tanzania. Article 146 (1) of the same constitution provides that the purpose of having local government authorities is to transfer authority to the people and consolidate democracy in order to accelerate development. The overall objective is to improve the delivery of services to the public and the main strategy is to transfer decision making power to the people and enable them to plan and control development efforts at local level (URT, 2012).

### 1.9.3 Local Government Reform

Heeks (2000), defines reforms as change within public sector institutions in seeking to improve performance in terms of service effectiveness and efficiency. Local government reform therefore can be understood as the change process and means and not an end in itself. Law often defines the function of public sector, law and order, environmental management, health and the government and national defence

services. Therefore, in the context of this study local government reforms encompass changes within public institutions, policies and laws, processes, systems and structures for improved public service delivery to the public.

### 1.9.4 Decentralisation

Conyers (1990) defined decentralisation as "the transfer of power and responsibility to plan, make decisions and manage public functions from a higher level of government to lower levels." Dubois and Fattore (2009) defined decentralisation as the "process of becoming" and "the state of being decentralized." The definition also encompasses the various dimensions that distinguished in decentralisation: the political, administrative and fiscal dimensions, which this study also considered critically important. This study embraces these definitions as they fit well in analyzing the decentralisation policy implementation in Tanzania as it signifying both the processes and the effectiveness of decentralisation.

### 1.9.5 Health Service Delivery

Kotler (1999) defined services as the perceived and tangible act or performance that one party offers to another. In the context of this study, service refers to those services as defined by law as functions of Local Authorities in Tanzania, which include provision of public health services. Health services encompass all services dealing with diagnosis and treatment of diseases, or the promotion, maintenance and restoration of health. It further covers personal and non-personal health services (WHO, 2015). Health services are the most visible functions of any health system to the public. Therefore, health service refers to the way inputs such as money, staff,

equipment, infrastructure, and drugs are combined to allow the delivery of health interventions (Tibandebage *et al.,* 2013). Improvement of access, coverage and quality of services depends on key resources being available and on the ways services are organized and managed, including incentives that influence providers and services users (Nyamuhanga, 2013).

### 1.9.6 Effectiveness of decentralisation

Local Government Authorities under the frameworks of decentralisation were mainly established legally to design, deliver and improve public services including health services. Effectiveness entails being responsive to the needs of the people and the degree to which health services provided are successful in producing desired result.

Effectiveness of health measures is based on the preparedness and capacity of LGAs in attending to the local needs as per their mandate. Focus of decentralisation was on how the systems, structures and processes cultivate a culture of rendering more demand driven services than supply driven services. The availability of resources and other facilities is critical in measuring the effectiveness of decentralisation for public health service delivery.

### 1.9.7 Access to Public Health Service

The World Health Organisation (2005) emphasizes access to public health in terms of population served and geographical coverage as well as range of health services provided. Shinde (2013) defines access to public health as a geographical coverage for health services in the society. This study understands access in terms of facility

availability in a geographical area to ensure that planned services are closer to citizens and respond to their needs and expectations. The measure of access includes coverage, availability, responsiveness, timeliness, readiness, ethical delivery, professionalism, resource availability and quality of health services.

### 1.10 Organization of the study

This study is organised in chapters and chapter sections. The first chapter introduces the study by exploring the theme and provides the context and premise of the study. It builds on the background information of the study to articulate the theme and sets the scene. The chapter also states the problem answered by the study. The research objective and specific objectives, research questions, significance of the study, scope of the study, limitations, definitions of concepts and organisation of the study are all covered in chapter one.

Chapter Two reviews relevant literature related to decentralisation and public health service delivery by drawing experience from various studies at a global level, from Africa and Tanzania as a specific case where the study focused. The chapter also documents some theoretical, empirical and conceptual issues in order to discern the foundations of the study and indicate the gaps in the theme under study.

Chapter three is about the research methodology and techniques adopted in data collection and analysis. Chapter four presents results of the study and discusses findings in respect of specific objective number one. In this chapter, demographic characteristics and their relational effect on the study theme are analysed and

discussed. The chapter also examines the effect of institutional characteristics on public health service delivery in rural Tanzania.

Chapter five provides the presentation, analysis and discussion of the findings under specific objective number two and three. The chapter makes a determination of the status of public health service delivery after decentralisation. It focuses on the perceived opinion of users and providers of public health service. The chapter also identifies and analyses the challenges met in the process and practice of implementing decentralisation for improved public health service delivery in rural Tanzania. Chapter six summarises the major findings, conclusions, contribution to knowledge and recommendations

# CHAPTER TWO

# 2.0 LITERATURE REVIEW

## 2.1 Introduction

This chapter reviewed literature related to public service and local government reforms, decentralisation and health service delivery. Substantial amount of literature covering theoretical and empirical evidence assisted the study to have a broad view of the issues pertaining to decentralisation and health service delivery. The theoretical debate and other case studies established the basis for the study to understand the insights on how institutional characteristics and arrangements affect the delivery of public health service and the status of public health service delivery because of decentralisation in rural Tanzania.

The review is structured with elements specific serving as key parameters of the study. Section 2.1 is an introduction, which indicates the essence for undertaking the review and the organisation of the chapter. Section 2.2 provides a theoretical setting adopted by the study to guide the review, methodology and data analysis. Further section 2.3 provides an overview on public service reforms, Local Government Reforms and decentralisation in order to get insights into the existing theoretical assumptions and empirical setting. Other provision in the introduction under section 2.4 is about decentralisation in Africa and its typologies. Under section 2.5 a review on Local government reforms in Tanzania and the quest for service delivery is given. In addition, section 2.6 highlights health sector reforms initiatives in Tanzania and section 2.7 gives a unique experience of Tanzania in decentralisation and service delivery. Finally, section 2.9 is on reflections and concluding remarks on the chapter.

## 2.2 Theoretical review

The understanding of decentralisation using governance approach, often believes to bring government closer to the people (Devas, 2005). When there are problems of synergism of public functions at the national level, whether founded on ethnical or historical bases, decentralisation may remove the obstacles of government decision making and public acceptability of government decisions. It also in general facilitates collective action and cooperation among all role players and the served public. This is because greater trust, capacity for collective action, and legitimacy of decision making often characterises homogeneous groups (Meagher, 1999).

Governance theory under the right circumstances believes that where government actions are transparent and civil society permitted to operate freely, decentralisation increases accountability of government officials and encourages all forms of responsiveness. The advocates of governance theory on decentralisation argue that public goods that do not have substantial inter-jurisdictional effects improve the allocation of resources, cost recovery, and accountability, and reduce corruption in service delivery. It further argues for improved governance in public service provision in at least three ways: by improving the efficiency of resource allocation; by promoting accountability and reducing corruption within government; and by improving cost recovery (Osborne and Gaebler, 1992).

However, this theory is criticised by institutionalism that it does not consider arrangements of systems and structures and their effect on decentralisation with regard to service delivery. Similarly, the role of systems, structures and processes

and its implications for service responsiveness and accountability are not considered. The governance approach has to take consideration on the effects of institutional arrangements on decentralized public service provision in particular. Institutions refer to formal and informal establishments with rules and practices that govern and regulate the behaviour and actions of individuals. In this sense, institutions may include jurisdictional designs, political systems and the structure that facilitate government administration (Stoker, 1998).

On the other hand, literature relating to decentralisation and public service delivery impinge the levels of public accountability in promoting decentralisation and service delivery. Support for this understanding is grounded on the influential works of Wallis and Oates (1988), who argue that decentralisation promotes downward accountability by placing the fate of local officials in the hands of the local people at sub national governments. As a consequence, decentralisation re-orients the flow of power relations, where local officials are no longer accountable to the central government but rather directly to the local citizens they represent in their jurisdictions. This enhances accountability as local citizens are capable to monitor the quantity and quality of services provided, and are thus capable of disciplining politicians and other local leaders by rewarding or sanctioning them in competitive elections. Given this possibility of 'exit', by the power of the local people, local officials provide public services effectively and efficiently in order to reduce the probability of being ejected (De Figueriredo and Weingest, 1997).

Given the fact that career prospects and upward mobility of public officials hinge

directly on the electorate, local officials become responsive to the demands of local citizens in order to signal superior performance and increase their chances of being re-elected or else promoted to a more responsible positions, political or administrative. Faguet (2014), challenges that, this approach focuses on how politics can be used to manipulate the citizens without clearly indicating how such accountability can be sustained and does not consider the nature and context of the society in which it takes place.

Besides its effects on competition for political positions and downward accountability, Smith and Revell (2016) argue that decentralisation increases responsiveness to local needs, by better targeting the provision of public goods and services, owing to an increase in information flows as well as frequent interactions between the local citizens and public officials. Decentralisation hinges on the assumption that establishing sub-national units reduces the problem of information asymmetry. In centralised systems, the multiplicity of vertical tiers of governance act as barriers to information flow, partly due to coordination challenges and varied incentives across bureaucrats (Treisman *et al.*, 2009).

On the contrary, in decentralised systems, public officials are better placed to make correct inferences on prevailing needs of the grass root citizens as a result of increased proximity and lower costs of obtaining and verifying information. This in turn leads to the provision of tailored public goods and services which are aligned with the demands and expectations of multiple segments of the local population (Leeson, 2013). In addition, given the spatial proximity at the sub-national level,

bureaucrats are well positioned to work in conjunction with community-based organisations (CBOs) and civil society organisations (CSOs) to identify prevailing problems and respond to these challenges through innovative and effective solutions. This argument is partly in line with Hirschman's (1970) concept of 'voice' under Public choice theory where decentralisation enhances the capacity of local citizens to express their needs and make choice as well as design services that match their preferences.

This study recognises the role of institutions in shaping individual behaviours and actions and their interactional effect, which in turn shape institutions. Kimaro and Sahay (2007) posit that, institutions are important framework of decentralisation. They help to make and examine on how interactions between agents and actors take place including on the bases of what is allowed, prohibited, and under what conditions. The institutional theory borrows a lot from systems theory, which also recognises the roles played by various structures, processes and actions. The system theory understands decentralisation as a system with inter related structures (ibid).

The principal agent theory is considered critical in revealing the roles of different actors in decision-making processes mediate access to public services among different users and enhance accountability between citizens and leaders. Bossert (1998) appreciates the importance of the two theories in analysing decentralisation reforms. The two theories focus on the trade-offs between different actors and the changes that decentralisation may bring with them. The two theories provide an opportunity to view the central government as an institution and as a principal with

the objective of improving the access, quality, responsiveness, affordability and equity of public services, and local governments as an institutions and agents' charged with responsibilities and resources to implement decentralisation policy to achieve the objectives of improving health service delivery.

Bossert (1998) emphasises that institutional arrangements, which include policies, laws and national guidelines as pivotal in ensuring decentralisation works for better service delivery. At the lower level, the citizens or service users and local politicians are principals with mandates to make decisions on local service delivery in line with needs and priorities (Batley, 2004). The interest of the study is on both the broader institutions at the centre as well as the local institutional arrangements as well as their interfaces, and how these arrangements affect decentralisation and subsequent public service delivery and decision-making processes and its outcomes at local levels.

Kimenyi and Meagher (2004) define institutions as the "structures of rules, procedures and organisations whether state provided or otherwise. Decentralisation for service delivery, therefore, entails restructuring institutions and creating new ones as its outcomes partly depend on institutional arrangements and their power relations (Azfar et al., 2004 and Batley, 2004)

The general principle is that having the right institutional framework results into optimal allocation and use of resources and leads to improved health service delivery to the communities (Mubyazi et al., 2004). Therefore, analysing decentralisation with a focus on institutional set up cannot be underestimated. Effective institutional

arrangements for public health services delivery are critically an important factor for inclusion.

Assessing the effectiveness of decentralisation and its results relating to public health service delivery largely depends on institutional arrangements in place, including power relations, and on the coherences of decentralisation policies in specific context (Smoke and Lewis, 1996, cited in de Palencia, 2010). The institutional theory upholds this assumption and informs the type of information needed for collection and the analysis. It is also an undisputed fact that successful decentralisation is the result of Local Government Authorities (LGAs) capacity to take own decisions and be accountable for their plans and actions as institutions and agents (Mawhood, 1993; Shah, 1998; Ribot, 2002).

After a thorough examination of the above approaches in relation to decentralisation and service delivery, this study aligns and centres within an institutional and the principal agent theories. The two theories are rich in terms of parameters that relates to the study under inquiry, the nature of the study and type of information suits to be analysed using institutional and principal agent theories, both of which accommodate interests, and role of different stakeholders. The relationship is summarised under the conceptual framework in figure 2.1.

## 2.3 Overview on Broader Reforms, Local Government Reforms and Decentralisation

Decentralization has been conceptualised in a variety of ways by different authors. Crook and Manor (1998) and Agrawal and Ribot (1999) define it as the transfer of

powers from central government to lower levels in a political, administrative and territorial hierarchy. Faguet (1997) defines decentralization as the devolution of all specific functions with all of the administrative, economic and political attributes by the central government to local governments. The later are independent of the centre and sovereign within a legally defined geographic area. UNDP (1997) refers to decentralization, as the restructuring or reorganization of authority so that there is a system of co-responsibility between institutions of governance at the central, regional and local levels according to the subsidiary principle of increasing the overall quality and effectiveness of the system of governance while increasing the authority and capacities at sub-national levels.

The history on reforming public institutions has been a matter of concern by many governments in both developed and developing nations. The thrust has been to improve service delivery. It is worth to note that embarking in reforming public sector institutions and public administration as a machinery is a complex and cumbersome process that requires political will and management support of the highest level (Corkey, 1998). It further acknowledge that, the more comprehensive the reforms are, the more complex they become hence the greater the management efforts and confidence needed to yield positive results and success (ibid). Mutahaba and Kiragu (2006) opined that for a country that embarks on public service reforms requires massive expertise, skilled workforce with requisite technical skills and other resources. In addition, such reforms should consider the prevailing policies, structures, systems, human and financial resource viability.

In the 1990s, the World and Africa in particular, witnessed changes in managing public service. Many African countries attempted to reform their public sectors as a response to prevailing political, economic, social and technological changes. The changes encompassed decentralising services to Local Government Authorities (LGAs) with the aim to improve efficiency, effectiveness and economy based on improved service delivery.

The 19th Century, witnessed a wave of reforms under the auspices of New Public Management (NPM). The emphasis was on Decentralisation for improved public service delivery at local levels (Osborne and Gaebler, 1992). The World Bank and International Monetary Fund have supported these institutional changes, which intended to transform the old administration, earlier considered as rule bound, hierarchical, unresponsive and inefficient than a more decentralized form of administration. Decentralised form of administration expected to be more responsive to citizen needs and effective in terms of assured access and quality of public services (Hope, 2001 and 2015). The focus has been to 'bring state institutions in' as opposed to earlier reforms which focused on 'rolling back the state institutions' away from the people (Beall, 2005).

The emergence of these reforms were deliberate initiatives to transform the government functioning in terms of organizational structure, policies and provision of institutional support for government decentralisation and managing the process hence bring change on service delivery (Pollitt,2004). Decentralisation and public health service delivery in developed and developing nations have been implemented

using new public management and institutional approaches as a guiding frame works (Hope, 2001; Batley, 2004; Larbi, 2005).

According to Andrews and de Vries (2007), countries have made strides on reforming Local Government under the theme of decentralisation of the fiscal, political and administrative responsibilities from central governments to lower tier governments for improved service delivery including public health service. The World Bank (2004) points out that "decentralisation must reach the local clinic, the classroom and local water utilities in ways that create opportunities for strengthening accountability between citizens, politicians and policy makers." The principle is that, in a decentralized system, public services should be more accessible and responsive to local needs. The argument base is that citizens directly or indirectly influence decisions about resource allocation and service delivery. The World Bank (2008) report also pointed out that, "Everyone is doing it" with a focus to enhance and improve service delivery to the lower level citizen.

Ng'ethe, (1998) believes that, in order for decentralisation to work, transfer of legal and political authority from central government and its agencies to the field is crucial. In Africa much of the sought powers technically remain held centrally and leaves much to be desired. Experience shows that evaluations of decentralization programmes in African countries have generally produced negative results, with very limited exceptions (Mollel, 2010: Massoi & Norman, 2009). However, scholars such as Azfar et al., (2004); Batley, (2004); Eaton and Schroeder, (2010); de Palencia and Pérez-Foguet (2011) in Masanyiwa et al., (2013) noted that decentralisation for

service delivery including health, entails restructuring institutions and/or creating new ones. This is because its expected outcomes partly depend on institutional arrangements and their power relations.

The World Bank (2010) points out that availability and access to infrastructure serves as pre- conditions for quality health services to the population. The same report further noted that, health clinics often lack the needed basic infrastructure mainly public clinics in rural areas. Pariyo et al., (2012) notes that decentralisation efforts still leave some odds as distance to health service delivery centres denies access and availability of health care especially to the poor. O'Donnell (2007) is of the view that access to health care is understood in a variety of ways. In its most narrow sense, it may refer to geographic availability of the services. A far broader understanding of access identifies four dimensions that encompass availability, accessibility, affordability, and acceptability. Similarly Peters et al., (2008), Ensor and Cooper (2004) noted that access to health service entails geographical coverage of service and availability financial resources, acceptability and quality of service provided.

Scholz et al.,(2015) observes that health care infrastructure constitutes a major component of the structural quality of a health system. Infrastructural deficiencies for health services reported in literature and research. They impinge on access, availability, quantity and quality. The role of health care facilities cannot be underestimated for they form a major component of a health care system management and delivery.

The World Health Organization (WHO) Alliance for Health Policy and Systems

Research provides six building blocks for health care systems. Infrastructure constitutes one of the components of the building block “service delivery”. The term ‘infrastructure’ is used in manifold ways to describe the structural elements of systems. In the context of a health care system management and delivery in reference to health care facilities, infrastructure defined as the total of all physical, technical and organizational components or assets that are prerequisites for the delivery of health care services.

### 2.3.1 Local Government Reforms in Africa

During the period of three past decades, most African countries have embarked on comprehensive public service reform programs including reforming sub national governments. However, despite the tremendous efforts and resources that have been allocated to this endeavour, progress remains scant and minimally impressive (Willis, 2005).

Most public service reform programs that have taken place in developing countries were introduced as part of the Structural Adjustment Programs (SAPs) of the World Bank in the 1980s. Most of the reforms were driven by a combination of economic, social, political and technological considerations, which triggered the quest for efficiency and reduced cost of delivering public services (OECD, 2005).

The World Bank and other donors for Africa have been concerned for alternative ways of organizing and managing public services and redefining the role of the State in giving prominence to the markets and competition, involving the private and

voluntary sectors in service provision. The alternative vision, based on issues of efficiency, representation, participation and accountability, has sought to create a market-friendly, liberalized, lean, decentralized, customer-oriented, managerial and democratic system.

Rob and Richard (2007) drawing inferences through case studies from sub-Saharan Africa have endeavoured to address the problem of how to develop (or restore) loyal, capable and efficient civil services. Civil services have been described as over sized, unresponsive, rule-bound or with no effective rules. They have low incentive, driven by corruption, patronage and red tape (ibid).

The public service (ministries, Local Authorities and departments) have always been the tool available for African governments for the implementation of developmental goals and objectives. LGAs are seen as pivotal for growth of African economies and poverty reduction and for driving improvement of citizen welfare (World Bank, 2004). LGAs are responsible for the creation of an appropriate and conducive environment in which all sectors of the economy can perform optimally. It is from this catalytic role of the public service that propelled governments all over the Africa to search continuously for better quality of public service delivery .and sustained economies (ibid).

### 2.3.2 Forms and Typology of Decentralisation in Africa

Decentralisation with its various types has been implemented in many African countries. The concept decentralisation is often used to describe different phenomena creating variations in terms of Interpretations leading to different conceptual

meanings, frameworks, programme, implementation strategies and implications. Such differences have invited debates and discussion.

Rondinelli (1986) opines that there are definitions which distinguish between types and forms of decentralisation. Typologies refer to what is decentralized and therefore encapsulate three areas: political, administrative and fiscal. The forms refers to the transfer of authority for making decisions to local units by central agencies (de concentration), lower levels of government (devolution), or semi-autonomous authorities (delegation). While de concentration and delegation imply a reorganization of central government, devolution means relinquishing political power. In addition, devolution as a type of decentralisation refers to transfer of governance responsibility for specified functions to sub national levels, either publicly or privately owned, that are largely outside the direct control of the central government.

Rondinnel *et al.*. (1984), further define decentralisation as the transfer of responsibility for planning, management, and resources raising and allocation from the central government and its agencies to: (i) field units of central government ministries or agencies; (ii) subordinate units or levels of government; (iii) semi-autonomous public authorities or corporations; (iv) area wide, regions, or functional authorities; or non-governmental, private or voluntarily organizations. There are a variety of different arrangements, which are often included in the discussions on decentralisation. Rondinelli *et al.* (1984) identify four major forms of decentralisation: Devolution, Delegation, Decentralisation and Divestment.

According to Rondinelli *et al.* (1984) devolution is the transfer of responsibility for governing, understood more broadly as the creation or strengthening financially or legally of sub national units of government, whose activities are substantially outside the direct control of central government. Rondinelli *et al.* (1984) further argue that, while devolution is the transfer of responsibility of governance, delegation is simply the transfer of managerial responsibility for specifically defined functions to public organizations (this can be local governments or parastatals) outside the normal bureaucratic structure of central government. De- concentration on the other hand, is the spatial relocation of decision-making, or the transfer of some administrative responsibility or authority to lower levels within central government ministries or agencies. While de concentration transfers some administrative responsibility to public organizations, divestment as another form of decentralisation, takes place when planning and administrative responsibility or other public functions are transferred from government to voluntary, private, or non-governmental institutions which clear benefits to and involvement of the public.

Ribot and Larson (2001) highlight two forms of decentralisation, Gregersen and Hermosilla (2004) and White and Philips (1996) identify four types of decentralisation which are political, administrative, fiscal and market decentralisation (privatization). Similarly, Rondinelli *et al.* (1984) on the other hand, identify four major forms of decentralisation (a) devolution; (b) delegation; (c) decentralisation, and (d) divestment. Therefore, it is clear that by types of decentralisation one can specifically refer to political, administrative and fiscal decentralisation. Likewise forms of decentralisation include devolution, delegation, decentralisation, and

divestment. The only difference between Rondinelli (1984) and White and Philips (1986) is that, the former identified four forms of decentralisation while the latter identified only three forms of decentralisation as stated above.

JICA (2007) notes that, decentralisation in African countries was introduced, adopted and implemented but the reality in terms of service delivery including health services has been disappointment. The 2000 World Health Report introduced the concept of stewardship as the most fundamental function of decentralized health system. Stewardship makes possible the attainment of the health system goals of: improving and promoting people's health; ensuring responsive and quality health service delivery and protecting citizens against the financial costs of illness (WHO, 2000). Africa, like any other continent of developing nations fits into the global picture of theoretical underpinnings and African scenario of Local Government Reforms under decentralisation policy.

One may conclude that, decentralisation is the transfer of power from the centre to the periphery whereby local citizens at the periphery participate in decision-making. The quest for decentralisation in Africa is a result of the inefficiency of the state especially the central government doing everything hence failing to deliver and consequently the need to decentralize was considered critical for improved service delivery in terms of reliability, access, quantity, quality, affordability, economy and timely delivery of service.

### 2.3.3 The Premise and context of Public Service Reforms in Tanzania

Changes within Public sector institutions are imperative and considered inevitable for such institutions to cope, align and adapt to new emerging economic, political, social and technological changes. The changes can encompass internal and external dynamics with varied demands. The ability to cope and align to such changes is one of the very critical elements that enable public institutions to apply new systems, structures, processes and working tools for effective performance of their mandated functions.

In Tanzania, Public service reforms dates back to 1961 after attainment of political independence. At the time of independence in 1961, Tanzania inherited a colonial system of public administration, which institutionally and structurally designed to serve the colonial government (URT, 2003). The reforms undertaken after independence were meant to build an institutional system with structures and processes as well as human resource capacity commensurate to the needs of a new nation (Mukandala, 2000). The main objectives of such reforms meant to boost and trigger development initiatives and change the public service from the colonial orientation to aspiration of a newly independent nation. Some of the efforts included indigenisation and politicisation of public bureaucracy (Mallya, 1988). Public servants were oriented to serve the public and offer essential services to citizens. Such initiative resulted in expanded access to social services, abolition of discrimination, improved ethical conduct in the public service and professionalism (Mukandala, 2000).

The Public service reforms after independence considered decentralisation with the guest to improve service delivery (URT, 2000). The Arusha declaration of 1967 also brought impetus for various changes in terms of systems, structures and processes in managing public service in Tanzania. Mushi (2002) and Ringo *et al.*, (2013) observe that, following the Arusha Declaration of 1967 with the Ujamaa philosophy as a guiding frame work, local authorities were abolished. The abolition of local authorities and the influence of Ujammaa resulted in dramatic expansion of the role of Government in all spheres; economic, political and social aspects, hence late 1970s and early 1980s the nation faced political, economic and social challenges (URT, 2000 and 2007 and Venugopal and Yilmaz, 2010).

It is important and worth to note that this section does not intend to detail the historical events regarding reforms in Tanzania rather to snap shot the genesis of reforms in the country. The interest of the study is on reforms that Tanzania embarked into in late 1990s and 2000s. The country took such initiatives to reform the central government and local governments with the intent to improve service delivery in both rural and urban areas (URT, 2003).

In Tanzania the central government reforms were the broad reforms referred to as Civil Service Reforms (CSRP) in the 1990s and later Public Service Reforms (PSRP I and II) in 2000s. These reforms implemented on sector specific including the health sector. The reforms at local government referred to as Local Government Reform Programme (LGRP). However, this study focuses on decentralisation implementation because of LGRP of 2000 following the passing and adoption of 1996

decentralisation agenda and Decentralisation Policy of 1998.

The LGRPs were implemented under the Decentralisation approach as a vehicle for improving public service delivery to citizens at grassroots level. The Public Service Reform Programme (PSRP) and Local Government Reform Programme (LGRP) were interlinked and related. The focus of this study is on LGRP, specifically Decentralisation and public health service delivery in rural Tanzania (URT, 2003).

The Health Sector Reforms (HSRs) implemented in line with the decentralisation policy of 1998. The National Health Policy (NHP) of 1995 that considered accommodating decentralisation with a view of improving health service delivery in terms of availability, access, reliability and quality in LGAs. The 1995 National Health Policy did not address clearly the issues of coverage of health services, distance to the health facilities, costs of health services, and availability of essential Medicare, out of stock medicine and medical supplies and human resource for health. The focus was on the category of health workers needed, working conditions, health facilities and disposal of waste materials and maintenance of medical equipments in the health facilities (URT, 2003; 2007). The 2003 and 2007 National health policies both categorically stressed on the use of decentralisation as a strategy in managing the health services and their delivery. Also the two policies addressed those issues and used decentralisation as an approach and driving strategy to achieve improvement of public health service delivery in Tanzania (URT, 2007)

The Civil Service Reform Programme focused on restructuring and overhauling the

then existing machinery (Mutahaba and Kiragu , 2002) The assumption was that the new efforts would cater for improved public service delivery including public health services which had seriously deteriorated. The local government reform programme that started in late 1990s was a result of the approval of Decentralisation policy in 1998. It is worth to note that such an effort was part of the broader initiatives taken for the entire public service reforms mentioned earlier (URT, 1998 and Baker, et al., 2002). The main objective of Local Government Reform Programme (LGRP) was to strengthen local government authorities and enable them to execute their role more effectively and efficiently in their geographical areas. The LGRP was expected to enable them deliver sufficient, reliable, predictable, affordable and quality services (URT, 2000 and 2002). The approval of this reform gained momentum after a series of consultations between the government and the donor community, in which some of the donors, such as the World Bank, pledged to assist the programme financially and technically. Increasing decentralisation was partly a response to the demand of these donors, as laid down in the Washington Consensus (Gore, 2000).

The guiding principle in the local government reform programme was Decentralisation by Devolution (D by D) with the thrust to improve performance of the public sector particularly local institutions, to increase accountability and to minimize mismanagement and waste of resources. In order to achieve this, it was considered imperative to give more powers, functions and resources to the people in the communities through empowering local authorities (Shivji and Peter, 2003).

According to the local government reform agenda, the new decentralized local government authorities were expected to be autonomous institutions, The local government authorities were expected to be free to make policies and operational decisions consistent with government policies without undue influence from the central government (Wariyo, 2009 and Ringo et al., 2013). In addition, LGAs were expected to be cost effective in their service delivery. The local government authorities were to be strong and effective by: possessing resources and authority necessary to perform their roles and functions mandated to them (REPOA, 2010).

It was hoped that local authorities would have adequate number of appropriately qualified and well-motivated staff who would be recruited and promoted exclusively on merit and provided with necessary training and upholding professionalism in local government; and having capacity to operate efficiently and cost-effectively.

The LGAs were expected to be noble democratic institutions. The leadership of the local government authorities was expected to be chosen through a fully free and fair democratic process, extending to village Councils and grassroots level, in order to: facilitate the participation of the people in deciding on matters affecting their lives, including planning and executing their development programmes; and foster partnerships with civic groups.

Another expectation was to improve efficiency in service delivery. The raison d'être for the devolution of roles and authority by the central government, and the existence of the local government, was to be the latter's capacity and efficiency in delivering services to the people. In order to achieve the intended goal, LGAs were

considered as subsidiary institutions. Each local government expected to have roles and functions that correspond to the demands for its services by the local people, and the socioeconomic conditions prevailing in the area. The structure of each local government would reflect the nature of its roles and functions. The local authorities were expected to be transparent and accountable institutions. This was presumed to be achieved based on their autonomy justified by being free from undue central government interference. Besides, local government leaders (councillors) and staff would adhere to a strict code of ethics and integrity (URT, 1996).

The principles of the local government reform as pointed out in the Policy Paper on Local Government Reform 1998 include, enabling the people to participate in government at the local level and elect their councils and bringing public services under the control of the people through their local councils. Giving local councils powers over all local affairs, improving financial and political accountability, securing finance for better public services, creating a new local government administration answerable to the local councils and creating new central-local relations based not on orders but on legislation and negotiations (URT, 1998).

In this context, local government authorities are thus institutions, which are multi sector units with a legal status operating based on general powers under the legal framework constituted by the national legislation. They are expected to deal with most aspects of the society and be to directly responsible for a wider range of sectors including public health service (URT, 2003). Local government authorities have responsibility for social development and the provision of public services within their

jurisdiction. They facilitate of maintenance of laws and orders and oversee issues of national importance such as education, health, water, roads and agriculture.

In line with the Local Government Reforms Programme, the role of central government institutions confined to the facilitation and enabling of local governments in their service provision, development and management of a policy and regulatory framework, monitoring accountability by the local government authorities, financial and performance audit, and provision of adequate grants.

Citing an example of the Council Health Service Boards (CHSBs), COWI and EPOS (2007) found that despite their elaborate roles and functions, most of could neither function properly nor meet frequently. This implies that CHMT members (agents) were minimally involved in CHSBs. They played minimal roles in preparing council comprehensive health plans (CCHPs), the main planning framework for health interventions in LGAs with or without inputs from Community health boards. This connotes that the process leaves a lot to be inquired and interrogated in terms of challenges affecting implementation of decentralisation for improving service delivery.

Boon (2007) indicates that the government dominates selection of CHSB members and that community representatives have no forum for consultation with their constituencies and have weak decision-making powers. Conyers (2007), on the other hand observes that, the effectiveness of management and user committees depends on their structure, composition, motivation and capacity of their members; and how

they are linked to the local and national structures. In this case, the presence of committees and service boards does not appear to have any meaningful contribution towards improving public health service delivery in LGAs under decentralisation.

Pablo (2010), in his analysis of the effectiveness of decentralisation and access to primary health observes that: if indeed a decentralisation process can produce larger positive effects on access to basic health services in developing countries of which Tanzania is of no exclusion, designing adequate decentralisation frameworks is crucial. This could help significantly in increasing the quality of life of their citizens through better access to services. This would together with other aspects, contribute to improve health outcomes of the population

Tanzania like any other developing nations fits into the global picture. The theoretical underpinnings and African scenario of Local Government Reforms under decentralisation policy also involve Tanzania because of her long and interesting history of implementing decentralisation reforms since independence. The country has continuously implemented local government reforms aimed at enhancing the quality, accessibility and equitable delivery of public services rendered by LGAs (Hussein 2014).

### 2.4 Local Government policies and laws in Tanzania

Local government in Tanzania is a non-union matter. It is nonetheless enshrined in the Union constitution. In mainland Tanzania, the Constitution of the United Republic of 1977, Articles 145 and 146 states that the National Assembly or the House of Representatives must provide for local government through legislation.

Article 146 states that one of the objectives of local government is ‘to enhance the democratic process within its area of jurisdiction and to apply the democracy for facilitating the expeditious and faster development of the people’.

Tanzania local government has a constitutional protection. Article 145(1) of the constitution, as amended in 1984, states that, “There shall be established local government authorities in each region, district, urban area and village in the United Republic, which shall be of the type and designation prescribed by law to be enacted by the Parliament or by the House of Representatives” (URT, 1977). Section 2 of the same Article categorically states that: “Parliament or the House of Representatives, as the case may be, shall enact a law providing for the establishment of local government authorities, their structure and composition, sources of revenue and procedure for the conduct of their business” (URT, 1977).

The purpose and functions of local governments stipulated in Article 146(1 and 2) of the constitution. Thus, it states; “The purpose of having local government authorities is to transfer power, responsibilities and authority to the people. Local government authorities shall have the right and power to participate, and involve the people, in planning and implementation of development programmes within their respective areas and generally throughout the country” (URT, 1977). In the above spirit of the above, each local government authority has the following broad functions:

- To perform the functions of local government within its area as defined;
- To ensure the enforcement of law and public safety of the people; and,

- To consolidate democracy within a polity and accelerate development of the people in their jurisdiction.

Besides the constitution, the legal framework of the local government comprises a number of laws enacted by Parliament, and these are:

- The District Authorities Act, No. 7/1982, as amended by Act Number13 of 2006;
- The Urban Authorities Act, No. 8/1982, as amended by Act Number13 of 2006;
- The Local Government Finances Act, No. 9/ 1982, as amended by Act Number13 of 2006;
- The Public Service Act Number 8 of 2002 as amended in 2008;
- The Local Government Negotiating Machinery Act of 1982, as amended by Act Number13 of 2006;
- The Regional Administration Act 19/ 1997 and ;
- The Urban Authorities (Rating) Act, 1983, as amended by Act Number13 of 2006.

According to the World Bank (2005) inability of citizens, especially poor citizens with low level of awareness on policies, laws and other accountability tools, affects levels of accountability. Failure to hold politicians accountable for resource misallocation decisions impairs access, quality and quantity of services. Norman and Masoi, (2010) also notes that, citizen with low levels of awareness and understanding on laws and policies guiding decentralisation affects their ability to make informed choices even when they are involved in decision making processes.

Noiset and Rider (2011) underscore the importance of laws as part of the key requirements for institutional mapping leading to fruition of decentralisation. The argument is that, dependence of local authorities to central government certainly manifested within legal framework that defines the existing relationship and the attendant outcomes. The central government controls resources, hence affects fruition of decentralisation for service delivery improvements. Kessy and Mc Court (2010) were sceptical on the role of decentralisation hence ironically regarded the same as recentralisation based on their analysis of central local relations on financing LGAs. JICA (2007) conducted a study on decentralisation and had similar conclusion that LGAs in Tanzania had no clearly defined functions. One would be interested to know why there has been such suspicion of lack of clarity on definition of the functions? The legal setting of Local Government Authorities is defined and described in broad terms with no limits of powers among various levels of central Government and LGAs. Ngaruko (2003) observes and emphasises the importance attached to institutional arrangement and relationship for decentralisation to be more meaningful in fostering service delivery.

## 2.5 Administrative Structure of Local Government in Tanzania

Decentralisation received a major push in 1996 when the government of Tanzania published the local government reform agenda. The subsequent policy paper of 1998 defined far-reaching decentralisation aims by promoting the famous principle: decentralisation by devolution. This approach aimed at devolution of power and authority to elected sub-national governments and not only a de concentration of central agencies. This far-reaching reform aimed fundamentally to re define the role

of the Central Government visa vis Local Authorities. The central ministries were expected to switch from direct implementation of policies to a role of support and monitoring of local authorities under the slogan “hands off, eyes on”.

Decentralisation reform started when the government and several donors committed their support in the form of basket funding for the Local Government Reform Programme that officially began in 2000. The programme implemented in phases. The main aim of the reform programme were to ; Devolve power to locally elected councils and committees (political decentralisation). Collection of taxes and budgeting based on local priorities (financial decentralisation); De-linking of local authority staff from the respective line ministries making them accountable to the local government (administrative decentralisation); and changing the role of line ministries from control to that of policy making, regulating, support and monitoring to ensure quality of services and national standards (Egli and Zuicker, 2002).

The local government levels divided into district authorities in rural areas and urban authorities in urban areas. The district authorities include district councils, village councils, and township authorities. The urban authorities divided into city, municipal and town councils that all have their own functions. The Local Government Authorities (LGAs) as institutions of service provision are have a hierarchy of management with an LGAs Head Office to coordinate the activities of the township authorities, Wards and village councils. These are accountable to the District Councils for all affairs as defined by law for day-to-day administration. The village and township councils have the responsibility to formulate development plans for

their areas (URT, 2002).

The local authorities have a number of democratic bodies to debate local development needs and plans. In the rural system, the "Vitongoji", that is the smallest unit of a village, is composed of an elected chairperson assisted by three members all of whom serve in an advisory capacity. In the Urban areas the "mtaa" (a small urban geographical area) is the smallest unit within the ward of an urban authority. Unlike the Vitongoji, the Mtaa Committees have a fully elected membership comprising a chairperson, six members and an executive officer."

The committees discuss priorities for local services delivery and development projects before the same are forwarded to the ward development committee (WDC). In the rural system proposal, reach the ward development committee (WDC) via the village council (VC).

The ward development committee members includes the elected ward councillor as chairperson, the ward executive officers, a salaried official, women councillors' special seat, representative from Non-Governmental Organizations and all village chairpersons within the ward. The ward development committee coordinates development plans and social service plans, supervises project implementation and service delivery activities, and is an intermediary for discussing initiatives from the sub-ward levels and the plans from the principal local authorities.

The village and township councils have responsibility for formulating development

plans for their areas, prior to securing district approval. Plans normally developed in association with formally established bodies. District councils and township authorities must have three standing committees: panning, finance and administration; education, health and water; and economic affairs, works and environment. Village councils have three standing committees namely: finance and planning; social services; and Defence and security (URT, 2006).

Statutory committees for both district and village councils include an HIV/AIDS committee and an ethics committee for the council. Local authorities have discretion to establish further committees, although there is a maximum for each type of authority. The role of the committees is to develop policy, set budgets and oversee the works of specified departments.

For urban councils, there are three types of urban authorities: town, municipal and city council. The chairperson of the town councils and mayors of the municipal councils and their relevant deputies are elected by the councillors. Urban councils have all the standing committees as in the case in district councils, including the discretion to establish new ones on demand. Non-elected members may be co-opted onto committees. **Figure 2.1** illustrates Administrative hierarchy and Authority flow in LGAs.

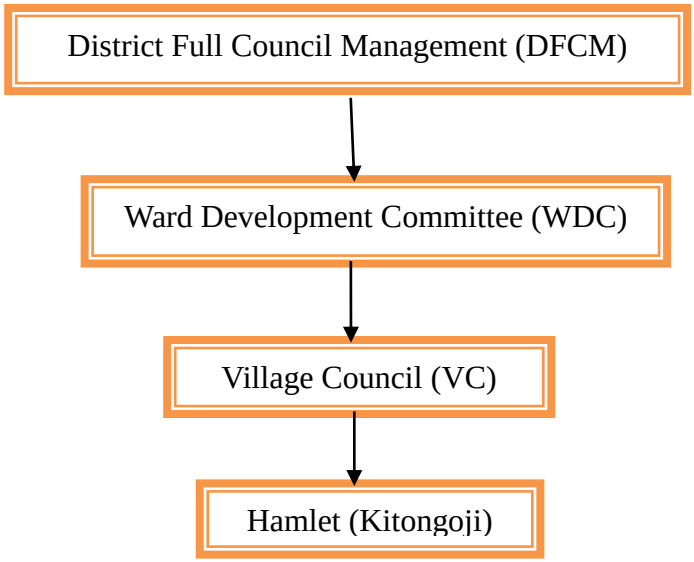


**Figure 2.1: Administrative hierarchy of a Rural LGA in Tanzania**

Source: Modified from URT, 2006

## 2.6 Local Government Reforms and Service Delivery in Tanzania

The reforms underscored under this sub section started in 1996 following the publication of the Local Government Reform Agenda 1996 and Decentralisation policy of 1998 that set the vision for the reforms (URT, 1996, 1998 and 2007). The reforms in LGAs in Tanzania mainly implemented in phases. Phase one of the local government reform programme (LGRP) implemented between 2000 and 2008. The reforms were implemented concurrently with health sector reforms whereby the health service at the District level was devolved to Local Authorities to increase their mandate in health service provision (URT, 2003). Under this arrangement, the expectation was that the health units including the District Hospitals (DHs) would provide services under the supervision of the Council Health Service Boards (CHSBs) and Health Facility Committees (HFC).

It was also expected that the duty of LGAs as democratic organs should be to ensure that, health facilities and services provided are of acceptable quality, managed by qualified personnel according to staffing level in line with the Ministry of Health (MoH) Policy Guidelines, Regulations and Standards (URT, 2003). Phase two of the reforms (LGRP II 2009-2014) were implemented from 2009 to 2014 with the same thrust to improve access and quality of Public health services..

The second phase of the local government reform programme implemented amidst other development policies and strategies, such as the Development Vision 2025 (URT, 2000) and the National Strategy for Growth and Reduction of Poverty (URT, 2010). The overall goal of LGRP II was to achieve "accelerated and equitable socio-economic development, public service delivery and poverty reduction across the country to achieve a middle economy." In relation to this goal, the overall purpose of LGRP II aimed to achieve devolution of government roles and functions hence transform Local government authorities (LGAs) to a competent strategic leadership and coordinators of socioeconomic development, accountable and transparent service delivery and poverty reduction interventions (URT, 2009).

Phase one and two (LGRP I and II) underscored the process of 'decentralisation as the main strategy to achieve the goals and objectives of the reforms and aimed at enhancing citizens' participation and improving service delivery, (URT, 1998 and URT, 2009). The Tanzania Government Poverty Reduction Strategy (TGPRS) document clearly spells out these reforms, the main objective being to improve service delivery to the public (URT, 2000; Ngware, 1992 and Lukamai 2006). The

Local Government Reforms as part of the major public sector reforms perceived as a driving vehicle of Decentralisation by Devolution in order to strengthen the local government authorities.

The overall objective of such an initiative was towards improving service delivery to the public through transferring power of the decision-making, functional responsibilities, and resource from central government to local government authorities (ibid). Even so, Shukuru (2006) points out that there have been cases of lack of involvement of stakeholders in planning process, alongside the human resources involved in the operational processes.

Article 146 (1) of the Constitution of the United Republic of Tanzania clearly gives powers to Local Government Authorities at all levels to ensure they deliver services to the people within their jurisdiction. The aim has been to enable LGAs to become autonomous, democratically governed and legitimate as they serve the people at grass root levels of society.

Despite these dimensions, the questions of interest amy include: what powers are transferred and to which local institutions are they transferred to. The answers to these questions determine the extent to which local institutions as recipients of decentralized powers, can effectively plan and implement development activities including provision of public health service provision (Conyers, 1990).

Decentralisation advocates believe it as a means of improving public services delivery. The assumption is based on the fact that, in a decentralized system

services are more responsive to local needs and demands of service beneficiaries because citizens can directly or indirectly influence decisions about resource allocation, size and quality service delivery (Conyers, 2007). Decentralized institutions expected to provide improved services in response to local needs and preferences and while ensuring accountability of local governments to their constituencies (World Bank, 2001 and Ribot et al., 2006). The World Bank (2004) stresses that decentralisation is an institutional mechanism that has the potential of enhancing the service users' voices in a way that leads to improved services.

These arguments are underpinned by the assumption that decentralisation of service delivery occurs within an institutional environment that provides the political, administrative and financial authority to local institutions, along with effective channels for local accountability and central oversight (World Bank, 2001; Azfar et al., 2004). It is believed that, the design of institutions with attendant structures, processes and actions can contribute to effective decentralisation results. However it should be clear that these are mere assumptions which need to be interrogated and verified through research.

According to Conyers (2007), the outcomes of decentralisation depend on the type of public services involved, the institutional design, the way is implemented, the capacity of institutions involved, and the wider economic, social and political environment. Hence, decentralized service delivery requires a mix of relations between central and local institutions, referred to as 'institutional pluralism' by Blair (2001). Many studies indicate that the necessary institutional arrangements for the

desired outcomes rarely observed. Most decentralisation reforms are either flawed in their institutional design or central governments do not decentralise sufficient power and resources to local level governments such as to enable them to lead to significant effective on local service delivery (Devas and Grant, 2003; Ribot *et al.*, 2006; Conyers, 2007).

## 2.7 Contextual Overview of Health Sector Reforms in Tanzania

The economic crisis of the 1980s, which also Tanzania went through, had a severe effect on the management and delivery of basic social services including health care services (Wangwe et al. 1998). The referred economic crisis affected the quality and level of provision of health care services to the community (World Bank, 1989). The crisis also resulted in shortages of medicines, equipment, medical supplies and low staff morale. According to URT (1994) and COWI et al., (2007), during this period, the Government stood as the key provider of free health care services. Private health care services were nearly nonexistent except for a few faith-based health care facilities.

In order to respond to and address these problems, the health sector was appraised in 1993 (Health Sector Strategy Note, 1993), and in 1994 Health Sector Reforms (HSRs) were proposed (URT, 1994). The proposal defined the health sector reform as a sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector. The HSR proposal aimed at creating an efficient, cost effective, equitable and decentralized health system. Specifically, the proposal aimed to improve the functioning and performance of the health system and, consequently

improve the quality and quantity of health services and foster their equity in improving access to health care services with particular focus on the poor.

In 1994 health, sector reforms were initiated hence resulted to the formulation of the first Health Sector Strategic Plan (HSSP1) and the Health Sector Programme of Work (POW) 1999 2004 to improve access and quality of health services. The health sector reforms were a comprehensive reform interventions implemented in tandem with the broad economic, social and political reforms that were on-going in the country with decentralisation as a strategy. The reforms were executed through Health Sector Strategic Plans (HSSP) (HSSP I 1999-2004, HSSP II 2005-2009, and HSSP III 2009-2015). (URT, 2009), All these initiatives aimed to improve the quality and quantity of health services by fostering equity, accessibility and affordability of health care services with particular focus to the poor in rural Tanzania.

The major components of health sector reforms were part of decentralisation whereby integration of district health care services categorically incorporated in the reform agenda (URT, 2007). The Ministry of Health under health reforms remained with policymaking, long-term macro planning and performance monitoring.

Districts were given authority to undertake local planning, management of health services, allocation of resources, financing and control of finances, supervision, monitoring, and evaluation. In addition, decentralisation became one of the key strategies for Primary Health Care (PHC) and means to ensure health for all is achieved by the year 2000 (WHO and UNICEF, 2004).

Despite all the efforts made, health problems and ill health continued to exist. For example, inequity in health care delivery is still predominant in many parts of the country. Health systems and programmes often blamed for inefficiency and ineffectiveness, putting them under pressure for reorganisation (URT, 2013).

### 2.8 Decentralisation and Service Delivery in Tanzania; A Unique Experience

Tanzania has implemented decentralisation reforms over the past one and half decade with the overall objective of improving the quality, access and equitable delivery of public services through local government authorities (LGAs) as observed in the previous section. Although decentralisation has been an important part of the nation's development agenda, there have been major variations in the forms that decentralisation has taken place. Earlier attempts show that from the 1960s to mid-1990s implementation of decentralisation was by 'de concentrating' and 'delegating' responsibilities to regional and local governments (Tordoff, 1994; Shivji and Peter, 2003; Kessy and McCourt, 2010). The initiative intended to achieve the planned restructuring of LGAs making them more responsive, effective and efficient in service delivery (URT, 1996, 1998, 2008, 2009).

In regard to health services, Sikika (2013 and 2014) points out that, availability of medical supplies, equipments and infrastructure and particularly in most of the public health facilities has been a problem that need special attention. The problem results in inadequate service delivery, unnecessary suffering and even death of innocent citizens. Literature empirically indicates for example that Geita Region had fifty four (54) health facilities inclusive of Health Centres and Dispensaries instead of the

expected 128 (ibid).

In an examination of the National Health Policy of 2007, Ifakara Health Institute (IHI) (2012), made a centralistic statement that. Health care in Tanzania is set by setbacks. This study questions the value and credibility of such a general statement. The questioning opens an avenue for a study to expose and elucidate the facts for such anomaly. Mamdani and Bangser (2004) opine that, public health services in Tanzania often not accessed by the very poor. The reason for such state of affair not provided clearly. This study certainly plans to provide answers to such questions and provides recommendations for improvement of public health service delivery to the rural poor. Missing of such important answers leaves a glaring gap that needs answers through research.

Reports on Human Resource for Health crises recognize and record shortage of health workers for the nation as one of the major bottleneck for achieving the Millennium Development Goals (MDGs), particularly those related to maternal and child health (URT, 2013). In 2012, The Ministry of Health and Social Welfare (MoHSW) reported a national shortage of about 113,000 health workers (URT, 2012).

Despite the efforts made, studies conducted on public health service delivery indicate that, corruption, nepotism and favouritism still exist in the management and delivery of public health (REPOA, 2008). Njunwa (2010), points out that Corruption is still widespread, in spite of the national anti-corruption policies and instruments.

Transparency International Corruption Index (2014, and 2015) Tanzania was ranked as 119 for 2014 and 117 for 2015 with a score of 31/100 for 2014 and 30-39 scale for 2015. This situation pushes and provokes this study to re interrogate the sub theme on the fact that time has elapsed since when those studies were conducted. In addition, the issue of approach used may certainly bring new insights. .

Other related studies focused on other dimensions of reforms also have been carried out including those looking at the fiscal aspects (Boex, 2003; Fjeldstad et al., 2004; Lund, 2007), political devolution and local democracy (Lange, 2008; Kessy and McCourt, 2010) and local government discretion and accountability (Venugopal and Yilmaz, 2010). Unlike previous studies, this study focuses on public health services. This study uses a different angle of analysis with two key parameters, which are access and quality of health services. Therefore, the health sector remains gray for more investigation.

Few researchers have examined the relationship between decentralisation and its effectiveness on public health service delivery. Adopting case studies for effectiveness of decentralisation on public health service delivery at the lower levels of ward and villages using the parameters used by this study is a rare. Related studies include those that examine the water sector (Cleaver and Toner, 2006; Foguet, 2010, de Palencia and Foguet, 2011) and the health sector (Mubyazi *et al.*, 2004; Boon, 2007; COWI, 2007 and Maluka *et al*., 2010).

Although some of these studies highlight the types of institutions created by the reforms to facilitate delivery and management of public services, little attention was

paid on the interplay between the local level institutional arrangements and the broader governance structures. Similarly, the differences and constraints in institutional arrangements between different sectors has not been fully explored.

Reforms have been implemented but the questions that remain relevant to many scholars and stakeholders include; what has been achieved so far since the implementation of decentralisation started under the prevailing institutional arrangements? Have there been any significant changes in the provision of public health services to the public in rural Tanzania? What factors explain distinct challenges holding back improvements in service delivery? In order to answer those questions and contribute to improvement of debate on decentralisation and pertaining literature in Tanzania, this study is envisaged to assess the effectiveness of decentralisation on public health service delivery. The main question is: to what extent have decentralisation been effective on public health service delivery in rural Tanzania. Specific questions includes; How do the institutional characteristics affect decentralisation for improved public health service delivery? To what extent has decentralisation affected public health service delivery in rural Tanzania? What are the challenges that affect decentralisation for improved public health service delivery in rural Tanzania that need immediate and future policy considerations?

## 2.9 Conceptual Framework of the Study

The conceptual framework for this study proposes that decentralisation reforms require pre requisite factors to improve services delivery. The conceptual framework mainly designed to reflect the theoretical understanding of decentralisation in relation to public

health service delivery. The framework shows the linkage of decentralisation in creating and conducive environment and favourable effect at Local Government Authorities. It further provides an opportunity to establish the relationships between various actors in the chain of public health services delivery under decentralisation. The actors includes those who are within and without as institutions, principals and agents on the other hand. In addition, the framework provides an institutional capacity to foster health service delivery in terms of accessibility, quantity, quality; affordability of services, responsiveness and accountability hence improved public health services (Cheema and Rondinelli, 1984).

The pre requisite conditions include policy and legal frameworks and subsequent policies, stakeholder's participation, Resource availability, financial autonomy in the LGAs, and socio-economic environment. These factors serve as enabling factors, whereas decentralisation reforms serves as an inputs, the subsequent emerging institutional arrangements (Decentralized management of health service delivery, increased users' participation and enhanced access and quality) serve as outputs, and improved service delivery serve as the outcomes. This conceptual framework and the theoretical underpinning has been used to analyse findings and formulate conclusions based on our findings.

The assumption is that, the role of related institutions in public service delivery cannot be under estimated in implementing decentralisation for service delivery in this study. At global level, the wind of change under the auspices of new public Management is a critical factor towards decentralisation and an agenda for Millennium Development Goals (MDGs) is another global issue towards

decentralisation for public health service delivery (Rondinnelli, 2006).

At national level, the factor include among others the late 1970s economic, political and social challenges, National Development vision 2025 and anti poverty strategies where decentralisation was considered as an ideal implementing strategy for decentralisation hence borrows a lot from the National vision 2025. The framework also appreciates that institutional arrangement and characteristics have bearing contribution on the effectiveness of decentralisation and its resultant outcome on public health service delivery in rural Tanzania.

The institutions include the legal framework, national guidelines, policies, government structure and operating procedures. In this study, the effectiveness of decentralisation on public health service delivery was measured in terms of access and quality which encompass the following parameters; availability, responsiveness of service providers, reliability, distance to the facilities, cost (affordability) to users' ability to pay. Matters of staff availability and their competence, availability of essential drugs, medical equipments and other supplies, responsiveness of service providers and their level of autonomy in decision making were also crucial.

Standing (1997) and Scholz and Flessa (2015) understand 'access' as a useful and straight forward concept to operationalise because it emphasizes the issues of distance and affordability of health services by users. The causal relations between decentralisation and improved quality of public health services can be assessed in terms of users' perceived changes on selected indicators, which include: availability of equipments and facilities, competent health personnel, drug availability, morale

and readiness to serve proximity of the health facility, quality of health facility buildings and their levels of satisfaction. Our focus will be on the 'perceived quality' of care from the viewpoint of users and not the 'technical' aspects of care (Gilson et al., 1994; Atkinson and Haran, 2005).

The WHO Alliance for Health Policy and Systems Research provides six building blocks on the bases of which health care system can be measured. In this study, the term 'infrastructure' is used in manifold ways to describe the structural elements of health systems. In the context of a health care system management and delivery in reference it refers to the total of all physical, technical and organizational components or assets that are prerequisites for the delivery of health care services.

The process of decentralisation involves three dimensions namely; political, financial and administrative to sub national levels of government. The political decentralisation is about devolving powers to set rules and regulations for sub national levels of governments. This empowers local councils to be the most important political body within a given jurisdiction (URT, 1998). Fiscal decentralisation refers to providing sub national governments with autonomy to levy and collect taxes, to widen revenue sources and to plan as per local needs and priorities (Ibid). Administrative decentralisation refers to how the local government staff delinked from controls of the central government regarding issues of recruitment, posting, performance management, promotions and discipline issues (URT, 1998). This study considers these three dimensions as critical to the study and has a bearing impact on institutional set up, character and its ultimate outcome on

public health service delivery. Figure 2.2 provides an illustrative picture on the interplay relationships between principals and agents as well as how the institutions are created and the relationships between the independent and dependent variables.

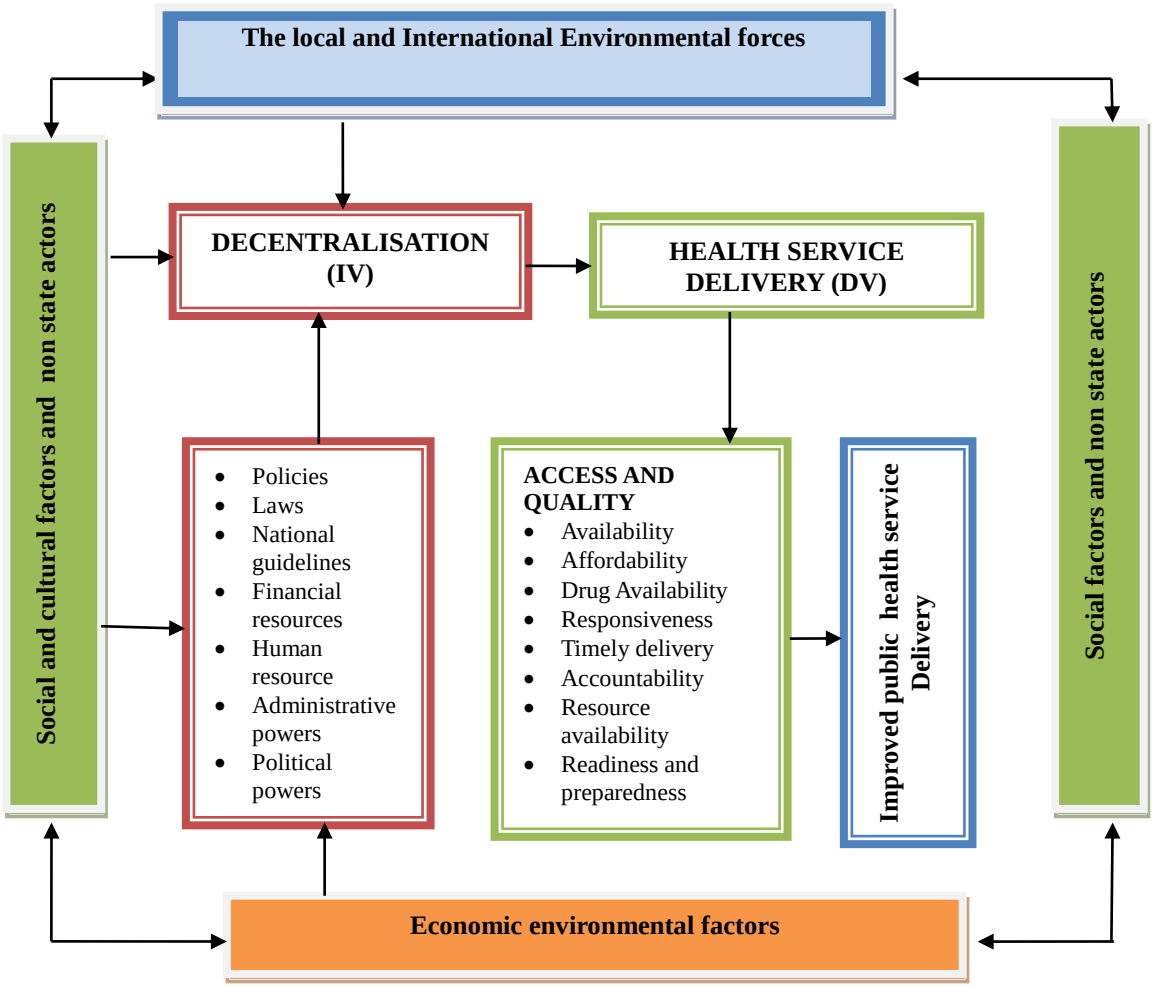


**Figure 2.2 A conceptual frame work**

Source: Modified after literature review (Cheema and Rondinelli, 1984).

# CHAPTER THREE

# 3.0 RESEARCH METHODOLOGY

## 3.1 Introduction

This chapter is about methodology and methods. The research design, methods and techniques for data collection and analysis clearly documented. The first part of the chapter is an introduction, followed by the research design, approach, sampling, study area context, data collection techniques and methods, results presentation, discussion and analysis as well as ethical considerations.

## 3.2 Research Design

According to Yin (2003), a research design is a plan that guides the researcher in the processing of collecting, presenting, analyzing and interpreting data. It shows and describes what will happen and procedures for data collection and shows techniques used in the entire study. It is the logical process linking data collected and the conclusions made in answering the questions of the study. De Vans (2001) on the other hand points out that a research design is a logical structure of inquiry whose main function is to ensure that the evidence obtained enables the researcher to answer the questions asked or test identified theories.

This study adopted a case study design method to get insights from multiple units of analysis at different levels of the selected Local Government Authorities. The study considered the design as potential and advantageous over other design as it allowed studying crosscutting issues at different levels in an intensive and comprehensive

manner. This design and approach also is supported by Yin (2003) who observed that case study design provides an opportunity to analyze multiple units of analysis at different levels to obtain insights in deeper ways about a research question under investigation.

This design was considered to be suitable for the study due to its relevancy in exploring the matter and issues when the boundaries between the phenomenon and context are not so clear evident where ‘why’ and ‘how’ questions are being asked and control by the researcher is limited (Yin, 2003). Intensive analysis was also possible by deploying case study design compared to other designs (Kumar, 2005).

The case study design was preferred as allowed discovery of causal relationship of variables hence provide description of a phenomenon under study within the context and complimenting the information with secondary information for precision and coherence of arguments. This approach also provides for validation of information collected and partly reduces the deficiencies and weaknesses as it allowed use of more than one method to collect data.

This study acknowledges the intertwined relationship that exist between local government as formal institutions as well as service providers and service users hence case study design to be an ideal for this study. The LGAs, Wards, Villages and service users were considered as critical units of analysis under this study to provide and shade light on those levels with regard to the effectiveness of decentralisation and public health service.

The analysis focused at District level, which is the most relevant level, and the highest level of analysis because this level is the decision-making point on resource and plans executions as well as coordination point of council plans. At this level Council chairperson was a focal person for interview and the management team responsible for health service delivery in the selected Local Authorities.

The second level of analysis was the ward level where councillors represent the citizens of all villages in a respective ward. It was also a critical level as a coordination point through ward health committees (WHC's) where priority decisions presumed to take place about rural health services. The lowest level of analysis was at the village and community level where the leaders and community members were involved. This level was also critical because at village level is where planning decision on resource, priority on service and service delivery and its effect takes place directly. The effect of institutional set up and its characteristics affects this level directly. Also at this level is where the interplay relationship of principals and agents take effect.

### 3.3 Context and Justification of the study area

As at December 2014, Tanzania mainland had 168 LGAS in main land Tanzania. Among of these LGAS, five were City councils, 17 Municipal councils and 146 District councils (ALAT, 2015). This study specifically focused on rural Authorities established under Act Number 7 of 1982 as a targeted population of the study. The study however mainly conducted in two District Councils of Pangani in Tanga Region and Urambo District Councils in Tabora Region. These are among the 146

LGAs legally established in the Country.

Of the two LGAs, one is Pangani that is off the shores of Indian Ocean in North Eastern part of Tanzania within Tanga Region. The second LGA is Urambo located in the Western part of Tanzania in Tabora Region. Both LGAs typically represent rural Tanzania, which was the focus of the study. Additionally, the two selected LGAs adopted and implemented decentralisation and have devolved powers and responsibilities to lower government levels since 2000 with intent to improve public health service delivery among others.

The two LGAs have similar institutional characteristics by virtue of their establishment and management. The choice of the two LGAs was informed by judgement matching size, time and resource to represent the totality of rural geographical area of Tanzania. The area size of Tanzania is about 945, 000 Square Kilometre hence the study could not manage to cover such geographical size. The nature of study design and approach also necessitated to study only two LGAs. Case study design allows in depth interrogation of a phenomenon and allows the use of more than one data collection technique to validate the information through triangulation.

### 3.3.1 Target Population

The target population for the study was 146 LGAs. However, only Pangani and Urambo Local Government Authority were selected and involved in the study. The choice was mainly done on probabilistic technique. The two LGAs were randomlly

selection from the total population of rural LGAs in Tanzania..

### 3.3.2 Sample and sampling Technique

Saunders, *et al..*, (2007) provides clear that sampling procedure has to be systematic and logical in order to ensure accuracy, precision, non bias and reliability of information gathered. The study drew the samples from Pangani and Urambo Local Government Authorities. Kothari (2009) defines sampling as the selection of some part of an aggregate or totality on the basis of which a judgment or inference about the aggregate or totality is made. It is the process of obtaining information about an entire population by examining only part of it. Therefore, sampling is a systematic way, which enables the study to choose a group that is small enough for convenient data collection, and large enough to be a true representative of the entire population from which it has been selected (Shipman, 1972).

Babbie (1992) noted that, it is not possible to study all the units of a population that interest the study. Sampling may be adopted for reasons of economy. It is clear that many studies carried out by the use of sampling could not have taken place if there had been no alternative to a full census. The objective of any sampling procedure is to get a sample, which will represent and reflect the characteristics of the population under study (Pons, 1988).

The two LGAs were chosen through probability sampling, which is simple random. The decision to choose the two LGAs consciously was made to collect focused information about institutional characteristics, status of public health services and to ascertain challenges related to implementation of decentralisation and service

delivery. The study considered the two LGAs to have typical characteristics to draw information needed for the study. The selected cases were representative because they are among the government key organizational structural levels that have implemented the reforms and have been affected by the policy actions since 2000. In addition, the two Local Authorities have similar institutional characteristics and organisational set up applicable to any other Local Authority in the country.

The two LGAs also draw their mandate from the Constitution of the United Republic of Tanzania of 1977 and Act number 7 of 1982 like any other LGA in Tanzania. Therefore drawing a sample from only two Local Authorities of Pangani and Urambo Local Authorities was considered adequate to draw representative conclusions on the effectiveness of decentralisation in respect of public health service delivery in rural Tanzania. The choice of methodology and data collection technique, was designed such as to use primary and secondary information, merits the conclusions to be drawn and paints a representative picture of the actual situation on the ground.

The respondents targeted for the study included, political leaders (Council chairperson). Also health personnel staff working in rural public health facilities available, Councillors from selected wards, village chairperson from visited villages and individuals (patients) who were found at available public health facilities and from communities as users of public health services to determine the status of public health services after decentralisation. This mix of participants provided a unique test and comparison on the effectiveness of decentralisation on public health service delivery in the selected case studies.

### 3.3.3 Sample Size and Selection Technique

The study expected to have a sample size of 320 respondents. The sample was divided into levels of analysis and categories from medical staff, Political leaders, village chairperson, patients and community members. The decision to use 320 respondents as a sample was informed by the fact that, if descriptive statistics are to be used, a good sample size should be between 200-500 respondents (Sudman, 2001).

Among these one hundred and sixty (160) participants was the targeted sample from each LGA. Thirty six (36) respondents were to be interviewed using semi structure interview guide for in depth interviews. Thirty two (32) were to form focused group discussions (FGDs) and the remaining two hundred and fifty two (252) respondents were expected to fill questionnaires. The actual sample size after embarking in the field was two hundred eighty two (282) which was 88.1 percent of the expected sample size. Table 3.1 provides the details of the actual number of respondents who were involved in the study by defined category.

**Table 3.1 Sample size from Pangani and Urambo Local Authorities (N=282)**

| Method of data collection | Pangani District Authority | Urambo District Authority | Total | Total % |
|---|---|---|---|---|
| Questionnaire | 103 | 120 | 223 | 88.4% |
| Interview | 13 | 14 | 27 | 75% |
| Focus Group Discussions | 16 | 16 | 32 | 100% |
| Total | 132 (82.5%) | 150 (93.7%) | 282 | 88.1% |

Source: Field Data, 2015

The respondents, who were interviewed using semi structure interview guides, were 27 and were purposively selected as key informants with rich information and experience about Local Government Authorities under decentralisation and public health service delivery in rural Tanzania. These included leaders of the two councils ranging from councillors, management teams as well as village leaders from the respective councils. The 203 respondents were service users selected through convenience sampling from the community members. The convenience sampling was used for the community members in selected wards and villages. Purposive convenience sampling offered several advantages, which include provision of greater precision, cost saving, time as well as guarding against having an "unrepresentative" sample.

In addition, 20 respondents were selected purposively to fill questionnaires. Specifically these were health personnel working in public health facilities located in selected wards from each LGAs. Purposive sampling mainly used to ensure that each category of persons the target population was represented in the sample hence raising the validity and reliability of the data collected.

However, the study could not get 100% of the planned respondents in the selected LGAs. The reasons include, some of the respondents did not turn up for interviews as scheduled and even when the researcher tried to arrange for other appointments, they did not cooperate. Similarly, some of the respondents did not return the questionnaires though the researcher made all possible efforts to make follow up.

### 3.4 Research Approach

This study was mainly qualitative and collected primary and secondary data of which later the same approach guided the analysis. The use of qualitative approaches in studying a social phenomenon attracts both critics and supporters (Mills and Huberman, 1994). The decision to use a given approach is always informed by the nature of the study, what the study intends to assess and type of data intended to be collected (Silverman, 2006). In recognition of those guidelines, this study used qualitative approach. Primary and secondary data collected from the selected local authorities triangulated for precision, credibility, validity and reliability of findings and conclusions.

In depth interviews were conducted with interviewees from the selected Council leaders who included council Chairperson, Councillors, Council management, village Chairperson and focused group. Observation was also partly used to establish the actual conditions of health services in selected LGAs in terms of physical conditions of facilities, behavioural aspects of employees and readiness to serve, responsiveness, availability of drugs and other related health supplies.

The gathered information was read then grouped into related themes and by the help of Statistical Package for Social Sciences (SPSS) they were made easy to analyse and discuss after creating tables and figures of frequencies and percentages for easy interpretation.

Secondary information excavated from policy documents related to health services, legislations, Government reports, and research reports, strategic plans from selected

LGAs, article journals and newsletters as well as parliamentary reports on health issues in Tanzania. Some of the specific documents reviewed included Decentralisation policy, Health Policy of 2003 and 2007, Constitution of the United Republic of Tanzania 1977, Public Service Act of 2002, Local Government Acts of 1982 and government reports on health performance reports.

### 3.5 Data collection methods and Tools

Decentralisation has depicted and indicated mixed and varied results on service delivery. The study deployed a mixed data collection methods, techniques and tools to ensure the information gathered is valid and reliable. The mixed method allowed the study to validate the collected information. The study used in depth interviews guide, questionnaires, focused group discussions and observation to collect primary data. Secondary data collected through review of various researches and articles, government reports, Policies, legislations, guidelines, government plans and budgets and literature review to get evidence from other settings. All the information was on public service reforms, decentralisation and public health service delivery.

#### 3.5.1 Field work

The fieldwork intended to run for a period of seven (7) months from July 2015 to February 2016. The sessions were conducted in two overlapping phases. Phase one involved exploratory investigation. Questionnaire administration combined with interviews and intensive Qualitative study as second phase. However, the National General Election interfered with the research schedule. The actual time spent in the field was nine months up to April 2016**.** (Refer Appendix 5).

The study made visits to the selected districts in order to explore and initially to familiarize with the study area and to collect available secondary data and to conducted interviews with district council officials on site. The study reviewed various documents relevant to decentralisation and health service delivery with a focus on those that could answer the main research question (Refer Appendix 5).

The study made an in-depth search of information related to health service delivery in the selected wards and villages within the two district authorities. The study used formal discussions to solicit from service beneficiaries, detailed information about the state of health service delivery. Questionnaires were used to extract data on perception on health services at individual level. Semi structured interview guides were also used to get information from staff involved in health services as well as from ward and Village leaders. The questionnaires and interviews ensured that the study and respondents remained focused on the matter of concern. The study used observation during field visits where physical occurrences of events were noted and pictures captured. The focus during the fieldwork was to search for information on institutional characteristics, status of health service delivery in rural areas and challenges affecting decentralisation for health service delivery in the selected LGAs in rural Tanzania (Refer Appendix 5).

### 3.5.2 Interviews

This study adopted the use of semi-structured interviews. According to Neville (2007), semi-structured interviews enable a researcher to omit or add to some of the questions or areas of interest depending on the situation and the flow of the

conversation.

The interview method adopted to gather information from the leaders of the two LGAs. This category included Council chairpersons, Councillors, Management team and village chairpersons. The advantage of this method was that, it allowed respondents freely and openly discuss issues under investigation. It also minimized bias of the interviewer. The interviews intended to investigate and obtain information related to institutional characteristics, status and challenges of health services in rural Tanzania linking the same with the main research question (Refer Appendix 1).

### 3.5.3 Questionnaires

The study used questionnaires to obtain information from the communities and service providers in health centres and dispensaries at Pangani and Urambo LGAs as selected cases. According to Saunders, Lewis and Thornhills (2003), questionnaires facilitate the collection of data from a large sample by asking such a sample to respond pre-determined questions.

The questionnaires consisted of open and closed questions. Open-ended questions, a question left a space for the respondent's own answer. In closed questions, a limited number of alternative responses were given for each question. These were in a list, category, scale ranking and other quantitative forms. The questions were pre-coded to facilitate their analysis.

The distribution of questionnaires was made easy through cooperation from LGA

leaders and health workers in concern areas. The LGA management helped through issuing an introduction letter introducing the researcher to the lower tires of local authorities. Questionnaires were distributed and picked later on agreed dates. In some cases, questionnaires were given to respondents who were attending health centres and were returned immediately after they were filled. This method enabled the collection of opinions and perceptions of community members as users of health services in the decentralized system in the two selected LGAs (Refer Appendices 2 and 3 ).

### 3.5.4 Focused Group Discussions (FGDs)

Qualitative research information collection can be through focus group discussions to get insight about a phenomenon. Kumar (2005) emphasizes that focus group discussion yields better results when the study is searching for experience and perception from a group of people with more or less similar experiences on the problem under investigation.

Morgan (1996) defines focus group discussions as a research technique that collects data through group interaction on a topic determined by the study in order to get not only perceptions but also experiences. Axinn and Pearce (2006) FGDs allows participants in a group to share, interact and formulate responses confidently while encouraging discussions than an individual would do in an ordinary interview.

The critical weakness of FGDs technique is when participants are hesitant and unwilling to participate to share their experiences or opinions. In order to address this

limitation, the use of other methods becomes imperative. In this study, four focus-group discussions (FGDs) were conducted in the two LGAs. They were all from service users, each consisted 8 participants. Information collected was relating to health services on availability of drugs, equipments, distance to health centres and geographical coverage issues. The responses were tape-recorded and field notes were written. The discussions centred around the main theme on effectiveness of decentralisation on health service delivery in rural Tanzania (Refer Appendix 4).

### 3.5.5 Non-participant Observation

Kumar (2005) defines observation as a method of data collection, which involves systematic and selective way of watching, and listening to an interaction or phenomenon on a particular topic as it takes place. Observations have the advantages of being relatively unstructured and can yield unique insights and reflections while allowing the researcher to put themselves into the shoes of respondents (Axinn and Pearce, 2006).

In this study, while collecting distributing and collecting questionnaires in health centres the researcher was able to see and directly perceive the service delivery standards based on availability, affordability, accessibility, working conditions, availability of facilities, complaint handling and feedback mechanisms in health services. This method was applied throughout the research process in order to ascertain availability of health services in the selected LGAs.

During data collection, the researcher was able to observe physically the real

situation in village dispensaries and health centres including the type of facilities and their physical conditions. The researcher was also able to observe means of transport used to reach health centres by citizens. The researcher had a privileged to see the physical conditions of working environment, tools, offices, delivery rooms and management of medical records in visited health facilities. This method allowed and paved an opportunity to generate real life experiences and realities from its origin form.

### 3.5.6 Documentary Review

Pons (1988) notes that, the documentary sources involves reading mainly in search of information and evidence related to the research interest. The past shapes the future. Hence it is impossible to fully understand the present unless one knows the past. Social scientist acknowledges the rich storehouses of data, which were accumulated in the past (Kester and Chambua, 1993). This study reviewed published or unpublished documents, which saved as effective sources of data relevant to the study. This study critically reviewed and analyzed various publications and documents including the following:

- The Constitution of the United Republic of Tanzania 1977;
- Relevant Acts especially local government Acts number 7, 8 and 9 of 1982 as amended in 2006.
- The Regional Administration Act Number 19 of 1997;
- Policy paper on local government of 1998;
- Strategic plans of the selected local government authorities.
- National Health Policy of 2003 and 2007,

- National Health Strategic plan 2005,
- Government reports on health performance and
- Government reports on decentralisation and researched academic articles and papers.

### 3.6 Validity and Reliability

Msabaha and Nalaila (2013) refer validation as a process of determining whether the instruments will gather the expected data or not. The degree to which the instrument can produce accurate data as required by the researcher is referred to as validity of research instruments. Once validity assured, then the data collected will certainly be accurate and reliable.

The instruments for data collection under this study were initially developed, discussed and agreed with the supervisor and later pre tested to validate them before they were adopted for data collection in the field.

### 3.7 Data processing and Analysis

Lincolin and Cuba (1988) found that proper data analysis depend on proper analysis as interpretations may lead to different results and conclusions. This study analysed collected data from interviews, questionnaires, Focused Group Discussion, documentary reviews and observation using contentment analysis. The analysis was made easy through the use Statistical Package for Social Science (SPSS Version 22). The collected data were cleaned, verified, coded, defined into themes and entered into the statistical package for social science to make them simple and manageable for analysis.

Descriptive statistics were available for easy reference in the analysis of phenomenon that emerged. This analysis led to the production of simple tables and figures for inference on the status of public health services in rural Tanzania after decentralisation. Descriptive analysis was done to determine the percentages of different variables and for drawing frequency distribution graphs and tables. Cross tabulation between variables to test, knowledge and awareness of the decentralisation of policies and laws hence examine the significance of the association between variables.

This was also useful in determining the status of health service delivery in terms of access, quality, affordability, ethical compliance, and availability and satisfaction level. The choice informed by the nature of the study where perception by service users and providers the study considered important. Content analysis involves words, pictures, symbols, meanings, themes and message communicated during the study (Mounton, 2001).

Qualitative data in terms of field notes, results from interviews, Focused group discussion and data from questionnaires transcribed, interpreted and organized into different meaningful themes. Analysis done on content basis after being transcribed according to the need to get the human understanding on the thematic issue under study.

### 3.8 Ethical Consideration

The study was conscious on ethical issues. Hence, measures were taken to ensure

that morals and ethics issues are adhered to. Research permits from the Government Authorities were obtained before embarking on the field for data collection. The clearance letter from The Open University of Tanzania introduced the the Executive Directors of the selected LGAs requesting permission for the study to be undertaken in their areas of jurisdictions. Letters were also sent to lower tiers of LGAs from the respective LGAs to ensure cooperation is met. Selected respondents were treated with confidentiality after they consented to participae in the study. . (Refer Appendices 6, 7 and 8).

### 3.9 Chapter summary and Conclusions

This chapter covered the methodology adopted in carrying out the study. It has given the framework and explained the whole research process adopted in order to arrive to findings and conclusions. The chapter has detailed the choice of methods and techniques and has indicated that the research design adopted was a case study. The justification for the choice of such design was also clear that the design was chosen based on the potential advantages attached to it compared with other research designs. The design was considered most relevant as it assisted the study to get insights from multiple units of analysis at different levels of local government administration. The study used qualitative approach to assess the effectiveness of decentralisation on health service delivery in rural Tanzania. The sample involved two LGAs (Pangani and Urambo). The rationality for the choice of such cases have been discussed in detail. Strategies for Sampling and justification of each strategy covered thoroughly. The chapter has also detailed data collection method, techniques and tools as well as ethical considerations. The analysis and justification to use

content analysis combining with SPSS in order to provide description of perception and feelings on the status of service delivery was also detailed.

The next chapter presents the study findings and discusses specifically the data relating to the effectiveness of decentralisation on health service delivery in rural Tanzania. The focus is on institutional characteristics and their implication on health service delivery, the section draws inference from the key research question and methodologies to draw meaningful conclusions and recommendations.

# CHAPTER FOUR

# 4.0 INSTITUTIONAL CHARACTERISTICS AND PUBLIC HEALTH SERVICE DELIVERY

## 4.1 Introduction

This chapter presents, analyse and discusses findings of the study from the first specific objective. The objective mainly examined the effect of institutional characteristics on decentralisation for improved public health service delivery in rural Tanzania. It builds on specific objective number one and is based on empirical data collected through questionnaires, interviews, focused group discussions and analysis of secondary data. Inferring from institutional approach, institutions plays a key role in shaping the interplay relationship between various levels and shapes the behaviour of actors as principals and agents in public health service delivery. Institutions also play a vital role in ensuring access, availability and quality of public health service. Institutions facilitate and ensure resources availability, working tools, human resource and LGAs autonomy in decision making which in turn affect public health service delivery. The findings from interviews, questionnaire, focused group discussion, documentary reviews provide explanation on how the institutional characteristics and their arrangements affect public health service delivery in rural Tanzania.

The chapter is organised in sections. The first section 4.1 provides an introduction and overview of the chapter. Section 4.2 presents the demographic and socio-economic characteristics of the respondents involved in the study. The information obtained from carefully designed questionnaires. Sections 4.3 present and discusses

the results of the study in reflection to the specific objective number one that is to examine the effect of institutional characteristics on decentralisation for improved public health service delivery in rural Tanzania. The last section 4.4 under this chapter is a chapter summary and conclusions.

### 4.2 Demographic Characteristics of Respondents and Interviewees

Demographic characteristics and Socio-economic profile of respondents provides the background information of respondents and interviewees. The study considered that demographic characteristics were important and had influence in the findings of the study, taking into account on the nature of the problem under study. Health issues under decentralisation have multifaceted effects on all groups of people within society. The analysis of the study findings cannot under estimate and ignore the importance and influence of respondents background and their demographic characteristics.

The respondents in this study were adult Tanzanians who use or who have used public health services provided by the local government from the selected LGAs. The analysis of data obtained from the cases intended to ascertain inter alia the level of experience of the respondents on the effectiveness of decentralisation on public health service delivery in their areas. Considering the purpose of the study, which sought to assess the effectiveness of decentralisation on Public Health Service Delivery (PHSD) in rural Tanzania. Several questions were posed to respondents related to health service delivery under the adopted and implemented decentralisation reforms in Tanzania.

The Dependent Variable (DV) in the study as pointed on the main objective as well as theoretical setting and conceptual framework is health service delivery in rural Tanzania. The dependent variable was tested in terms of availability of services, distance to health centres, accessibility of services, affordability of services, timeliness delivery of services, quality of services, rule of law and human rights observance, proper records keeping and Procedures for complaint handling.
Furthermore, the level of maintenance of services such as sanitation, professionalism, combating and prevention of corruption and citizen participation in decision-making were tested. All these issues were central in this study as key indicators for service delivery in the LGAs and particularly Urambo and Pangani District councils.

The Independent Variable (IV) in the study was the ongoing reforms and to be more precisely the Decentralisation reforms for improved health service delivery. The decentralisation process and its implementation actions were analysed focusing on institutional setup, power relations, policies, laws, resource allocation and availability, implementation guidelines and regulations. Furthermore, consisted political factors, social cultural, the role of international donors and none state actors. All these shaped and influenced the outcomes of decentralisation on health service delivery. Other variables included sex, marital status, employment type, age and education levels of respondents as summarised in Table number 4.1.

**Table4.1 Demographic Characteristics from Service Users (N=203)**

| Characteristic | Number | Percentage |
|---|---|---|
| **Sex** | | |
| Male | 87 | 42.9 |
| Female | 116 | 57.1 |
| **Age** | | |
| 18-25 | 36 | 17.7 |
| 25-35 | 74 | 36.5 |
| 35-45 | 41 | 20.2 |
| 45-55 | 31 | 15.3 |
| 55-60 | 13 | 6.4 |
| 60 and Above | 8 | 3.9 |
| **Marital status** | | |
| Married | 136 | 67.0 |
| Single | 51 | 25.1 |
| Window/widower | 12 | 6.0 |
| Divorced/separated | 4 | 2.0 |
| **Occupation** | | |
| Employed | 16 | 7.9 |
| Businessmen/women | 39 | 19.2 |
| Student | 20 | 9.9 |
| Famer/Livestock keeper/Fisherman | 128 | 63.0 |
| **District** | | |
| Urambo | 110 | 54.2 |
| Pangani | 93 | 45.8 |

Source: Field Survey, 2015

### 4.2.1 Sex, Age and Marital Status of Service Users

The respondents were asked to indicate their sex, ages, marital status, education levels and occupation status. The ages of the respondents was categorised into six groups. The first category comprised those who were aged between 18- 25 years old, the second group between 25-35 years old, the third group between 35-45 years old, the fourth one between 45-55 years old, fifth between 55-60 years old and the last group comprised those who were 60 years old and above. The Study results indicated that 36.5% of respondents were aged between 25-35 (36.5%). This was the leading age group and followed by 35-45 (20%).

This study considered age as an important variable as it had an influence with regard to health services. According to the findings, it implies that for those who participated in the study were the most active and productive group politically, economically and socially from the selected LGAs. The two age groups (25-35 and 35-45) form a group of household leaders and were the ones who were more affected directly or indirectly by decentralisation policies and public health service delivery. There were only 36 (17.7%) respondents aged 18-25 years and 31 (15.3%) respondents aged between 45-55 years. The other category of respondents was that with 55-60 years and those aged 60 and above all together comprised 10.3% of the total respondents' rate. However, all these age groups the study considered important in the analysis and discussion of the findings of the study as they paint a picture based on experience and exposition to public health service delivery in their respective area.

The study established that, age set has a direct relation with decentralisation and public health service delivery in Tanzania. The Constitution of the United Republic of Tanzania 1977 and other laws categorically recognise that citizens can be involved in decision making from the age of 18 years and above. This study took also cognisance of the same in analysing institutional characteristics and public health service delivery in rural Tanzania.

The study also indicated that, more women than men participated in filling the questionnaires. The women were 116 out of 203 which is (57.1%) of the total respondents who participated in the study while 87 were men equivalent to 53.1%.

Table 4.2 summarises through cross tabulation the facts on sex of respondents for the two studied local authorities of Urambo and Pangani.

**Table 4.2 Sex of respondents Cross Tabulation**

| | | Sex of respondents | | |
|---|---|---|---|---|
| | | **Male** | **Female** | **Total** |
| Name of district | Urambo | 49 | 61 | 110 |
| | Pangani | 38 | 55 | 93 |
| Total | | 87 | 116 | 203 |

Source: Field Survey, 2015

The high percentage of women implies that women were more affected by decentralisation and public health services, as they were the ones who were at most found in dispensaries and Health centres visited. Those women were either attending Clinic or bringing their children for medical services. Culturally it implies that women are the ones who take most care of children in the family.

Marriage also played an important role in analysing decentralisation and health service delivery in rural area when determining the status of health services. This study required respondents to state their marital status. The marital status of the respondents was grouped into four categories: single, married, Widow/ Widower or Divorced/ Separated. Table **4.1** summarises the findings under this variable. The findings indicated that 136 (67%) of respondents from the user side who participated in the study were married at the time of the study, 51(25.1%) were single, widow or divorced all coming up to 16(8%).

The analysis indicated that those who were married had higher demands of seeking

health services than those who were not married. Interviewees from the supply and user side also added that;

> "...those in marriage especially those with children do attend more frequently for health service seeking than those who were not married...".

### 4.2.2 Occupation Status of Service Users

Employment and other type of economic engagement contribute and influences ability to afford costs related to access health services. It was assumed that the employed, whether in formal or informal employment, generate some income and hence have financial power to pay for health services. These costs include travelling costs, costs for medical check-up, drugs and medicines all of which are expected to be under the cost sharing policy of health in Tanzania. **Table 4.1** presents a summary on occupation status of the respondents from service users.

The respondents who participated in this study from the user side were mainly peasants, livestock keepers or fishermen all comprising 128 or (63%) of all the respondents. This paints a true picture of rural Tanzania whereby 80% of residents live in rural areas and largely depend on farming and livestock keeping. Through documentary review, the study established that two-thirds of Tanzanians reside in rural areas and rely on local health facilities (Dispensaries and Health Centres) run by their Local Government Authorities (Boex et al., 2015). Those who were employed as well as students, businesspersons, and women collectively accounted for 75 (37%). The study indicated that the employed as well as those with economic power through farming and live stock keeping had an influence on the provision of health services in the community. For example in an interview, with one Medical

Officer at Pangani, she said, I quote and translate accordingly;

> "In our District where the majority are peasants and livestock keepers, ,,,,,they are divided in terms of ability to afford the costs for health services. Those who are livestock keepers are seemingly to be more capable financially and able to pay for medical services. The peasants income is seasonal, during the harvest season they relatively manage to pay. In addition Women who frequently attend in health centres and are given prescription and costs for medicines tend to revert back to their husbands for financial support for health services"

The study established that, economic status affects the level of access to health services. Some have to travel long distances to get health services and need to meet costs for check-up and medicines. This was tested when respondents were asked to indicate their views on the need for a health facility within their village. They were asked on the issue of distance to get health services if it was shorter than it was before decentralisation. The Details on these issues appear in Table 4.5. Through observation, the study was able to establish that, citizens attend health centres using bicycles and few used motor cycle. This was applicable for both Pangani and Urambo. Nevertheless, the findings from one of the four focused groups discussions, in answering the question about distance had this to say; I quote and translate;

> "Some of us travel for more than five Kilometres to get health services at Mwera. In our village and ward, there is no health facility. Also is expensive to hire a motor cycle, as the means of transport are unreliable other means of public transport available. This becomes even more severe when someone falls seriously sick at night".

The above findings indicate and imply that, those without income, systematically and structurally denied access to health services. During data collection from dispensaries and health centres, the study observed citizens attending at dispensaries using motorcycles and bicycles as the main means of transport. This information was

validated through documentary review in Pangani where the report from the District Medical Officer (DMO) indicated that, the entire Local Authority had only one health centre at Mwera ward against the requirement of thirteen (13) health centres. Similarly, in Urambo there was only one heath centre at Usoke. This implies that, for citizens in the referred LGAs access and availability of public health services is an issue that had minimally attended as expected and as was promised by the decentralisation and the National Health Policy of 2003 and 2007.

### 4.2.3 Levels of Education of Respondents

This study considered education as an important factor in exploring the effectiveness of decentralisation on health service delivery. The arguments largely anchored on the fact that assessing awareness on policies and its effects is multifaceted in the level of knowledge, understanding and exposure of respondents. The study found that, educated respondents were more capable and more informed than those who were not educated. The implication of this finding is that, respondents whose levels of illiteracy was low could decimally make informed contribution and participation in decision-making.

The Study results as shown in **Figure 4.1** indicated that 137(67%) of the respondents had primary education, those who had secondary education were 45(22.2%), adult education and those with education above secondary education were only21 (10.8%).

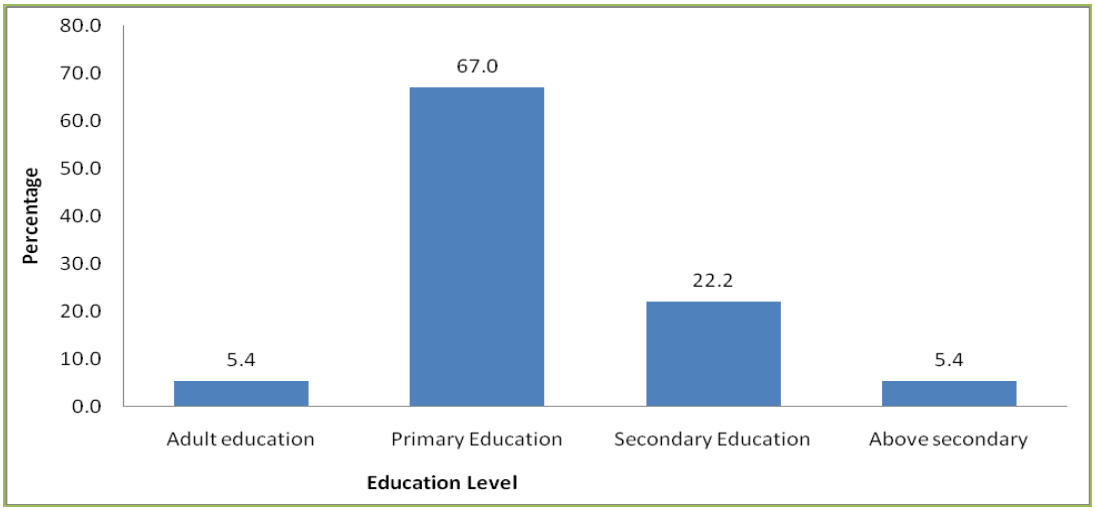


**Figure 4.1: Levels of Education of respondents from Service Users (N=203)**

Source: Field survey, 2015

### 4.2.4 Education and Age Status of Health Service Providers

This study considered education as an important factor in analysing effectiveness of decentralisation and health service delivery from the perspective of health service providers. The arguments mostly relied on the fact that assessing awareness on policies and its effects is multifaceted in the level of knowledge, understanding and exposure of service providers.

Assessing the quality of health service, education and capacity of service providers were critical. The study found that, educated respondents were sufficiently aware about the decentralisation policy and other laws than those who were not educated. The study also found that education had direct relation with the quality of health care provided by the supply side.

The implication of this finding was that many of the respondents were literate where 17 (85%) of the total respondents had college education with certificates and

diploma. The study also indicated that 9 (45%) were Medical doctors/ interns and 11(55%) were nurses and medical attendants. The study findings also indicated that most of the service providers who participated in the study were of the age range of 36-60 (60%).

These findings imply that, the respondents who participated in the study were experienced in the provision of public health services in rural Tanzania and hence well informed about decentralisation and health service delivery. The study believes that respondents had knowledge of the issue researched. The study results are summarised in Table 4.2.

**Table4.3: Demographic Characteristics of Health Service Providers (N=20)**

| **Sex** | **Number of Respondents** | **Percentage** |
|---|---|---|
| Male | 9 | 45 |
| Female | 11 | 55 |
| **Age** | | |
| 18-35 | 8 | 40.0 |
| 35-55 | 8 | 40.0 |
| 55 -60 | 4 | 20.0 |
| **Marital status** | | |
| Married | 12 | 60 |
| Single | 4 | 20 |
| Window/widower | 4 | 20 |
| **Occupation** | | |
| Medical Doctor/ Student/ Internship | 9 | 45 |
| Nurse /Hospital Attendant | 11 | 55 |
| **Level of Education** | | |
| Primary education | 2 | 10 |
| Secondary education | 1 | 5 |
| College education with Certificate or Diploma | 17 | 85 |
| **District** | | |
| **Urambo** | **10** | **50** |
| **Pangani** | **10** | **50** |

Source: Field Survey, 2015

## 4.3 Institutional Characteristics and their Effects on Public Health Service Delivery

This section focuses and seeks to account on specific objective number one of the study. The objective aimed to examine the effect of institutional characteristics on decentralisation in relation to public health service delivery in rural Tanzania. In addressing this objective, the study posed one fundamental question, which intended to ascertain how institutional characteristics affected decentralisation for improved public health service delivery in rural Tanzania?

The study tested the knowledge and awareness level of the respondents in terms of their understanding of local government policies and laws, systems, structures and practices. The study thought it important to find out whether the respondents were aware of local government policies and laws because the laws and their effect on access, quantity, quality and the general delivery of public health service delivery under decentralisation in rural Tanzania.

The understanding of these policies and laws was considered as an important variable as institutional framework for effective implementation of decentralisation policy for improved health service delivery. Decentralisation and public health service delivery have been implemented using the new public management approach and institutional approach as a guiding framework. The Institutions, which include policies, laws, guidelines, regulations and administrative systems and structures, are vital in the analysis and discussion of decentralisation for service delivery as indicated in the conceptual framework in chapter two.

Institutions play an important role in shaping individual behaviours and actions and their interactional effect, which in turn shape institutional processes and practices. Institutions are important framework in making and examining how interactions between principals and agents as actors take place. They also encompass what is allowed or prohibited, and under what conditions with regard to service delivery.

In order to address this objective the study used mainly qualitative approaches to ascertain awareness of respondents on the nature and character of existing institutions and structures as well as their effect on decentralisation for improved public health service delivery in rural Tanzania. The institutional theoretical underpinning as well as the conceptual framework informed the analysis. The analysis used primary and secondary information to establish the linked effect of those policies, laws, administrative structures and practices as institutions on public health service delivery in rural areas of the selected Local Government Authorities (LGAs).

The next section 4.3.1 present, analyse and discusses the findings for the first specific objective, which focuses on institutional effect on decentralisation for improved health service delivery linking to the main objective of the study.

### 4.3.1 Public awareness (Service Users) on Decentralisation Policies and Laws

The study under this sub section intended to assess the level of awareness of service users on policies and laws guiding decentralisation as part of examining the institutional characteristics. The results of the study as presented in **Figure 4.2**

established that 92.6% of the respondents from the user side in the selected LGAs were not aware about the country's decentralisation policies and laws. The study established that the low level of such awareness in rural areas attributed by low level of education and sensitization initiatives by respective LGAs. The fact is, about 67% of the total respondents from the demand side had primary education. **Figure 4.1** in the previous section presents the fact from the field. To this regard the study considers and is of the view that education levels and exposure resulted to low levels of such awareness on decentralisation policies and laws

The study also established that level of awareness impaired the level of accountability on health service delivery by citizens. The study is of the view that, such level of awareness affects the quality of public health service delivery and access hinders people from participating in meetings and make meaningful contributions to decisions on issues that affect their welfare including holding public servants accountable.

The implication of low levels of awareness entails inability of citizens, especially poor citizens in rural areas failing to hold politicians accountable for resource allocation and decisions that impair access, quality and quantity of services. The study analysis has positioned on the fact that, citizens with low levels of awareness and understanding on laws and policies guiding decentralisation affects their ability to make informed choices. The citizens considering their value in the chain of principal agency relationships they become passive and even when they are involved in decision-making processes.

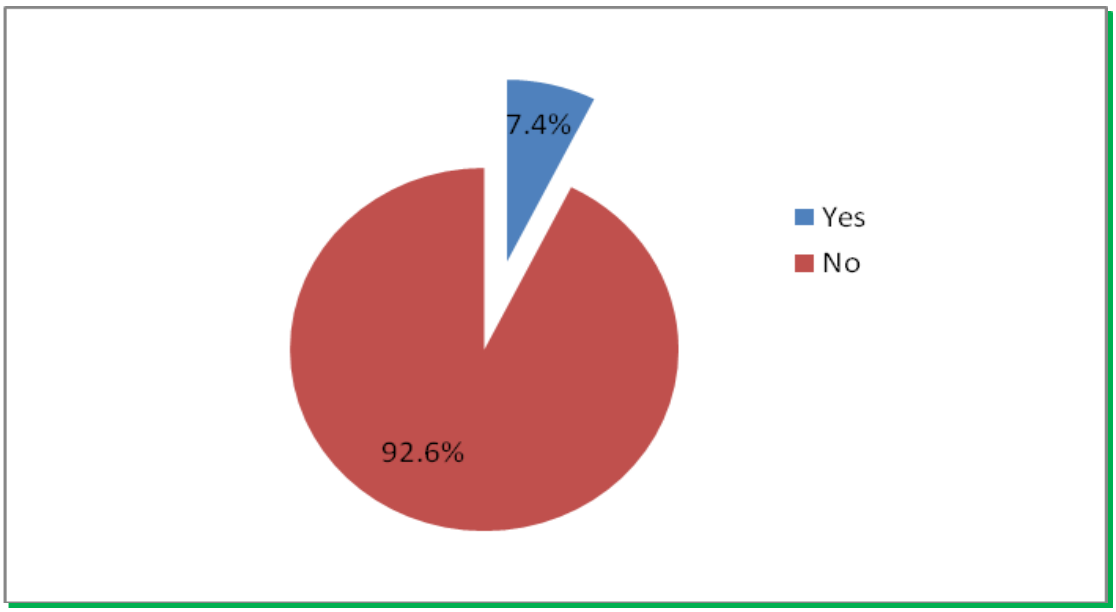


**Figure 4. 2 Citizens' Awareness on the Decentralisation Policy and Laws (N=203)**

Source: Field survey, 2015

The situation was contrary from the service providers, whereby 65% of service providers were aware on decentralisation policy and laws. The respondents from the supply side and those who participated in the interviews were aware of the decentralisation policy and other laws. They were able to point out some of the policies and laws such as decentralisation policy paper of 1998, local government laws, as well as the United Republic of Tanzania constitution of 1977. **Figure 4.3** summarizes the results.

One interviewee from the management of respective LGAs who was a councillor asserted that lack of awareness on policies and laws by citizens affects performance of LGAs in the areas of accountability on resources, good governance and affects

negatively the quality of public health services provided by LGAs. When asked on how he knew and became aware on decentralisation policies and laws, he had the following to say, I quote and translate;

> "My awareness is a result of workshops and familiarization seminars attended by virtue of my position as leaders of LGAs. I had an opportunity to attend workshops and seminars organised by the LGA and also accessed those documents given as working tools"

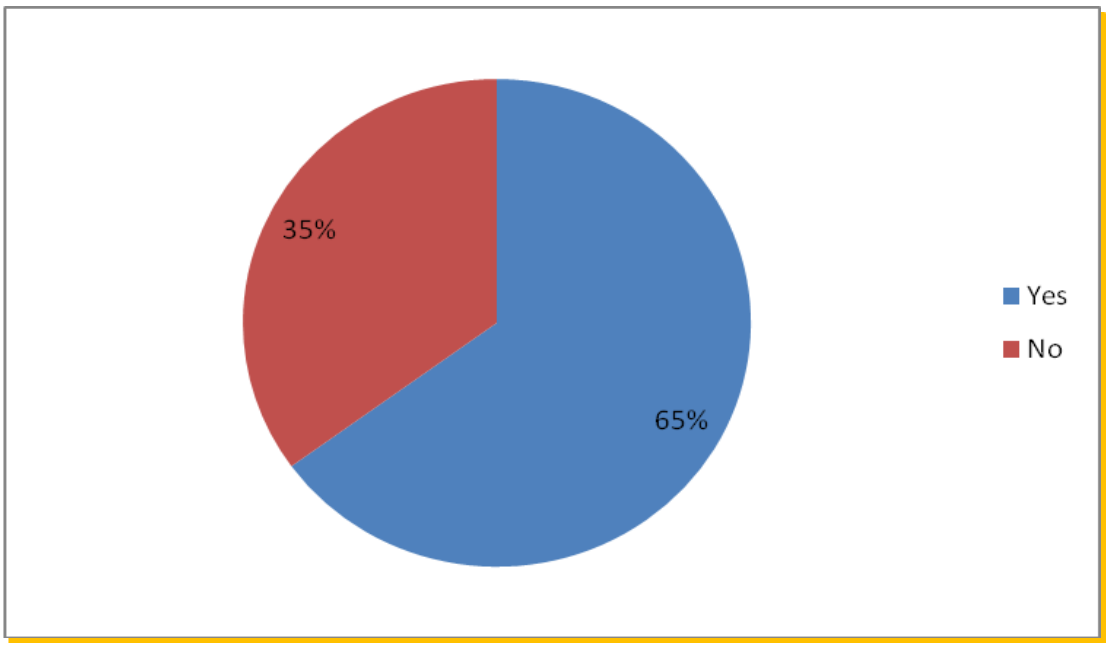


**Figure 4.3 Awareness on the Decentralisation Policy and Laws (supply side) (N=20)**

Source: Field survey, 2015

### 4.3.2 Effects of Policies and Laws on Health Service Delivery (Demand side)

The study thought it imperative to know from both demand and supply side whether decentralisation policies and laws contributed towards improved provision of public health service delivery in rural Tanzania. The study established that, 78.8% of

respondents from the demand side, as users of public health services were sceptical about the effectiveness of decentralisation to improve public health service delivery. This implies that decentralisation process and action minimally contributed towards improving public health service delivery in rural areas particularly in the selected LGAs for the study. **Table 4.4** indicates the summary of results.

**Table 4.4 Effects of Policies and Laws on Health Service Delivery (N=203)**

| **Items** | **Number** | **Percentage** |
|---|---|---|
| Do the decentralisation laws and policies helped to improve public health service delivery | | |
| Yes | 43 | 21.2 |
| No | 160 | 78.8 |
| Do decentralisation laws and policies help citizens to access public health services | | |
| Yes | 20 | 9.8 |
| No | 183 | 90.2 |
| As a citizen are you satisfied with the institutional set up between the central government and local government in improving public health service delivery | | |
| Satisfied | 76 | 37.4 |
| Not satisfied | 116 | 57.1 |
| Don't know | 11 | 5.4 |
| Does the existing policy on decentralisation and laws empower to make autonomous plan and budget related to public health without interference with central government | | |
| Yes | 44 | 21.7 |
| No | 159 | 78.3 |

Source: Field Survey, 2015

Similarly, results from focused group in Pangani at Msalaza Village, indicated that the effect of decentralisation is on the increase of number of Dispensaries. However, these respondents alluded that the built up dispensary in their village had no health

workers. The health centre in the neighbouring village though has health workers, the services provided were not sufficient. Therefore, they had this to say;

> "We still have no reliable health centres in our ward and village. The built health centre has no staff to provide health services needed therefore in our village we prefer using a health facility owned by religious institution where their services are relatively better than those given by the government which has no staff and other facilities".

Decentralisation as an institutional reform and policy action was hoped to bring services closer to the users and respond to local demands. In terms of health as pointed out earlier the expectation was to improve access and availability of public health services as to geographical coverage. Therefore, the scepticism from the demand side and as principals, the study established that, the small number of health centres, dispensaries as well as lack of facilities to support delivery contributed to such state of affair. Secondary data informed that, to achieve major and sustainable improvements in local health outcomes needs under decentralisation requires ensuring adequate resources provided. Such resources should include health staff, drugs and medical supplies, funds for operational expenses as well as other health-related resources. The resources should reach the primary health facilities that form the front-line of public health service delivery in rural Tanzania.

The information from one Councillor as Political Leader from Urambo in an interview as key informant had this to say; I quote;

> "I have been a councillor for two terms and we have been talking about bringing services near to people but it is almost fifteen years the distance and number of health facilities has not increased much in number as expected to improve availability and access. Women are the most affected as in our tradition they are the ones responsible for taking care our children. Also when they are pregnant they fail to attend regularly for

> clinic for check-ups. The facilities available lack important resources including health workers and related equipments to support the delivery of needed health services in our area".

The study through review and examination of documents which were made available, it was established that at Urambo LGA for example, during the study had fifteen (15) Wards but had only one ward with Health Centre (HC) at Usoke, instead of fifteen Health centres which were supposed to be in place as per National Health Policy Commitment statement. In the case of dispensaries, there were fifty nine (59) villages but only 20 villages had Dispensaries (D).

Pangani Local Government Authority had 14 wards and 33 villages but there was only one (1) Health Centre (HC) at Mwera ward and only sixteen (16) dispensaries in sixteen villages. This situation defeats the objectives stated in the decentralisation policy and The National Health Policy 2003; 2007, which categorically provided that every village should have a dispensary (D) and every ward should have a Health Centre (HC) to ensure that services are closer to people.

The data on structural arrangement and management when analysed indicated that, the structural arrangement and the management structures of Health services in Tanzania are both decentralised and centralised at the same time. The policies and laws, which form a profound part of an institutional framework for effective health service delivery under decentralisation lacks clear definition of responsibilities among actors. The study established that institutional arrangements and spaces for the exercise of control between multiple principals and agents affect access, availability and quality of public health service delivery in LGAs. Similarly, the legal

framework plays important roles in the institutional arrangements for decentralized service delivery. It determines which functions to decentralize and which ones to centralize. This study established that such tendency has created some principal agent problems, thus limiting LGAs' autonomy to execute their decentralised functions and particularly health services. **Figure 4.4** Summarizes the health structure as per National Health Policy of 2003 and 2007 in line with Decentralisation thrust agenda.

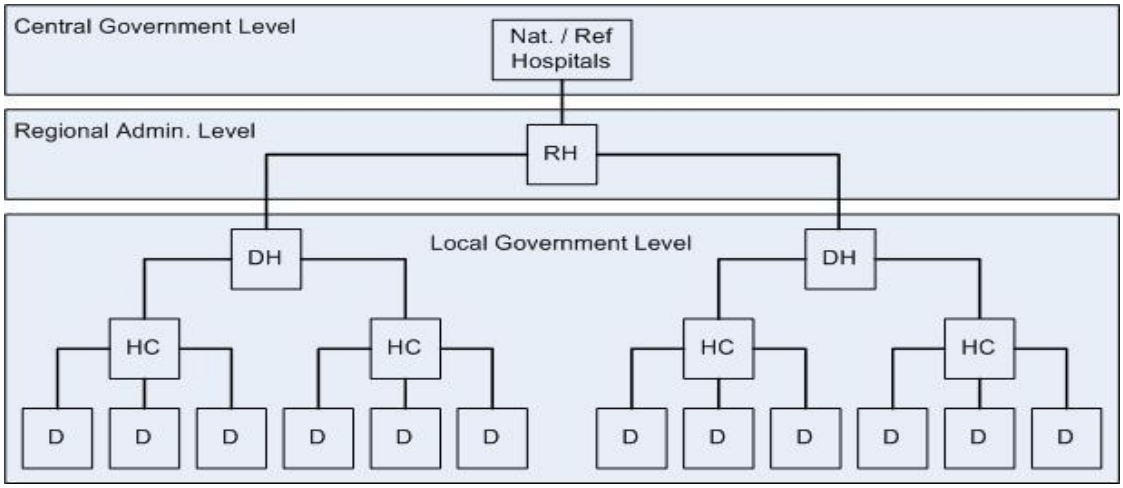


**Figure 4.4 Organizational Structures for Health Service Delivery in Tanzania Mainland**

Source: Boex, 2015

Access to health care is understood in a variety of ways, in its narrow sense, access to health refers to geographical availability of service. Broadly understanding of access, four dimensions can be put forward; availability, accessibility, affordability, and acceptability. In the context of this study, it is a fact that access in the selected LGAs was relatively still an issue at remote to materialize, especially in terms of number of health facilities in wards and villages. This entails people still have to

walk many Kilometres and long distances to access health services.

The national health policy and decentralisation policy provides it clear that, access has to be understood using similar parameters hence creating a health system as shown in Figure 4.4 as an operational tool to cascade and decentralize health service management and delivery in Tanzania to local levels.

The study further underscored the issue of whether decentralisation laws and policies help citizens to access public health services in the selected LGAs, it became clear that 90.2% of the respondents from the demand side who participated in the study indicated that access was still a problem in their areas hence denied them access. The study further intended to establish if citizens were satisfied with the institutional set up between the central government and local government in improving public health service delivery. The study also established that 57.1% of the respondents were not satisfied. Moreover, the study went further and asked respondents whether existing policies on decentralisation and laws empowered them to make own plans and budgets related to public health without interference by central government. The findings indicated that 78.3% of the respondents did not agree that LGAs were autonomous enough to draw and execute their plans for health. **Table 4.4** provides a summary of results. Such state of affair implies that, the existing policies and laws as depicted in the conceptual framework do not cultivate a conductive and an enabling environment for decentralisation to be effective and yield the expected results on public health service delivery.

The study analysis through triangulation of collected data, established that, the

infrastructure for decentralisation in terms of laws there were issues that needed to be addressed for the same to bear fruition of results. The information collected from key informants through in depth interviews at Pangani highlighted the issue of delayed supply of medical supplies and reagents with other facilities from the medical stored department. The key informant asserted, I quote;

> "Hierarchy in ordering of drugs, medicines and other medical supplies pose a challenge in health delivery in our area. Numbers of Heath centres and dispensaries have serious shortage of medical supplies due to the bureaucratic system of ordering drugs and other medical supplies. The procurement procedures and distribution system are so cumbersome and causes delays of medical supplies reaching the delivery points..."

This study also through in depth interview with two councillors at Pangani Mwera and Bushiri wards established that, there was a mismatch in LGAs priorities on health needs and those of National levels. The two councillors complained about the failure of their Local authorities to respond to local priority needs. They cited diseases, which were perceived by community members as major health problems in their respective areas but were not reflected or were given low priority in council plans. They asserted;

> "Community involvement in health planning and delivery is very minimal. District health plans do not beam identified community needs through the bottom-up Opportunities and Obstacles (O&OD) planning process that is supposed to be the basis for LGAs plans. LGAs officials ignore village plans and give priority on national priorities for which funds are available".

This suggests that LGAs to greater extent are still implementers of national and sector wide development policies and programmes with little reference to local priorities. In addition, documentary reviews and citing empirical evidence from Ghana, Code d'Ivoire, Kenya and Zimbabwe established that even where democratic

representation mechanisms exist, local governments have not been responsive enough to local needs and community aspirations (Crook, 2003).

Further, an analysis of Local Government Act of 1982 as amended in 2006 as well as the Constitution of the United Republic of Tanzania of 1977 and the Local Government and Regional Administration Act number 19 of 1997. The study established that levels of responsibilities between the central government and local government authorities were still unclear. While there is consensus on the fact that decentralisation has a significant potential to enhance accountability and to promote local participation in public service delivery, there is less consensus in the degree to which this is necessary for improved public service delivery including health services for that matter.

Some of the policies and laws show overlaps that affect the autonomy of LGAs. The laws have some claw back clauses, which are bottleneck for the realisation of planned outcomes of decentralisation. They retard the level of autonomy to LGAs. Therefore the study considers that fruition of decentralisation to improve public health service delivery largely depend on its design and on the institutional arrangements governing its implementation.

The study made also documentary reviews. Through follow-up on parliamentary sessions (Hansard reports) the study established that, members of Parliaments from rural councils who sit also in council meetings, have been posing questions to the government relating to deficiencies and shortfalls in services provided by rural

Health Centres and Dispensaries in the wards and Villages (URT, 2014, 2015 and 2016). This implies that access and availability because of the existing instructional framework has not met the expectations to its fullest note.

### 4.3.3 Effects of Policies and Laws on Health Service Delivery (Supply side)

The analysis from the supply side (service provider) established that, the respondents who were health workers agreed by 75% that the decentralisation policy had significantly contributed towards improvement of public health services in some aspects. On the issue of decentralisation laws and policies, whether show commitment by the central government to decentralize? The service providers agreed by 60% that there are some commitments, which are significant at that level. On the other hand 40% disagreed. This indicates that there were issues that needed to be worked upon as 40% of respondents cannot be ignored.

The study also established that 65% of respondents from the supply side agreed that existing policy and laws on decentralisation empower them to execute their plan and budget related to public health. However, 35% were sceptical on the issue of autonomy. The study also intended to assess if respondents do think that there any relationship between decentralisation and improving public health services delivery in local government in rural Tanzania. Where 60% agreed that there was a relationship and potential for improving service delivery while 40% said there was no relationship. **Table 4.5** summarizes the results.

**Table 4.5: Effects of Policies and Laws on Health Service Delivery (N=20)**

| Items | Number | Percentage |
|---|---|---|
| Do the decentralisation laws and policies helped to improve public health service delivery | | |
| Yes | 15 | 75.0% |
| No | 5 | 25.0% |
| Do decentralisation laws and policies show commitment by the central government to decentralize | | |
| Yes | 12 | 60.0% |
| No | 8 | 40.0% |
| Do existing policy on decentralisation and laws empower you to execute your plan and budget related to public health | | |
| Yes | 13 | 65.0% |
| No | 7 | 35.0% |
| Do you think there any relationship between decentralisation and improving public health services delivery in local government in rural Tanzania | | |
| Yes | 12 | 60.0% |
| No | 8 | 40.0% |

Source: Field Survey, 2015

The analysis through triangulation of data obtained from the interviewees, Councillors, Village chairperson, District Medical Officers and District Health Secretaries, established that the improvement were not comprehensive to draw robust conclusions that access, quality, quantity and responsiveness had been achieved.

The analysis noted from key informants and secondary information that there were critical shortages of medical staff, facilities and medical supplies. Through an interview with informant at Urambo Local Authority, had this to say; I quote and translate;

> "Our requirement for health workers (human resource for health) which includes doctors, nurses, laboratory technologist, chemist, attendants and administration staff for the entire Local Authority to suffice the need is

> four hundred and sixty three (463) staff. The actual available staffs are two hundred and thirty seven (237) staff only. The deficit is two hundred and twenty six (-226) staff. At Usoke Health centre there is a mortuary but there is no mortuary attendant"

Another observation from interviewed key informant at Urambo was the issue of coordination problem. The interviewee had this to say;

> "Policy issues about health care are under The Ministry of Health while implementation is under Local Government Ministry. This segmentation is very complex and confusing. Orders and instructions flow is not very clear among stakeholders in this sector."

In this regard, the discussion and analysis established that there was a problem in ensuring effective implementation of decentralisation and hence have significant results on improved health sector. Amelioration of such situation calls for revised coordination mechanisms among stakeholders to ensure effective decentralisation and service delivery improvement. In order to counter check if the responses on contribution of decentralisation had contributed on improving rural health services, the respondents were asked also if the same has contributed towards availability of medical equipment and related supplies.

Through a review and examination of drugs and medical supplies receiving schedule report at Pangani, the study established that, essential medicines, medical supplies and equipment were not adequately available. The ordering schedule was the reason for delayed supply and sometimes failing to deliver at all. This in turn resulted to un availability of medical supplies in most of the public health facilities, leading to unnecessary suffering and even deaths of innocent citizens.

The next sub sections 4.3.4 provides an examination by analysing the structure of

Local Government Administration in Tanzania and the quest for improved public health service delivery in rural Tanzania. This section provides a synthesis on the structural framework and its implication on decentralisation on health service delivery in rural Tanzania.

### 4.3.4 Government Structure and Its Implication on Health Service Delivery

This section provides an examination on the Government Structure, nature of LGAs in their legal frameworks and their implication on decentralisation and health service delivery in rural Tanzania. Therefore the section points out and discusses critically the issues that it considers to affect decentralisation for improved public health service delivery in rural Tanzania in line with the conceptual and theories guiding the study.

There are two tiers of Tanzania Government, which is to say, Central Government and Local Government Authorities. Chapter 1 Article 1-3 of the Constitution of the United Republic of Tanzania of 1977 and their subsequent sub articles provides for the proclamation and formation of Central Government while Articles 145(1-2) and 156(1-2) establish Local Government Authorities (LGAs) in the country and spell out their respective functions (UTR, 1977).

The study analysis and discussion established that the legal framework and the administrative structure of central government in Tanzania is complicated and is conflicts with the plan for decentralisation of government functions to local levels. The policy, theories of decentralisation and practice leaves a lot of puzzles and problems in delineating the roles of principals and agents in the provision of public

health service delivery. The centre controls the periphery hence affecting levels of autonomy to Local Authorities and its subsequent service delivery.

An in depth interviews of selected respondents in the study established that the level of autonomy of LGAs is questionable due to overlaps in the powers and authority between the two tiers of government. There are also conflicts in the functions and responsibilities between Districts Administrative level and LGAs hence causing redundancy. One of the councillor who was an interviewee from one of the wards in Pangani claimed that; Quoted and translated;

> "The policy, legal and structural framework are the main cause of conflicts in the roles and responsibilities of central and local governments hence negatively implicating decentralisation initiatives. The Constitution and other laws do conflict hence indicating elements of a unitary state system which emphasizes on centralization of power, authority and responsibilities"

In a review of secondary information to validate the above, the study observed that a unitary state system allows all the three organs to be governed as one single government. Whereas, political powers have been devolved to LGAs, the central government has powers to recall and retain the same powers at the centre (Boyne, 2007). Ngaruko (2003) observed and emphasised the importance attached to institutional arrangement and relationship for decentralisation to be more meaningful and foster service delivery.

The study established that, although LGAs are legal entities, the analysis of legal instruments including the Constitution and Local Government Act Number, 7 of 1982 as amended by Act Number 13 of 2006, established that The Constitution empowers the President to have discretion on their existence. The President has

constitutional powers to establish or abolish any office in the United Republic of Tanzania including LGAs. The study also found that, The Minister responsible for Regional and Local Government Administration has powers over LGAs, has powers to accept or reject any proposal for establishment of new LGAs in Tanzania (URT, 1977, 1982 and 2002).

This observation entails that initiatives to decentralize are farfetched and inherently affected by the institutional arrangements in the country. Either most decentralisation reforms flawed in their institutional design or central governments do not decentralise sufficient power and resources to local level governments to enable them have significant effect on local service delivery. The study was able to establish that, The National Health Policy (NHP) on addressing decentralisation sates that,

> ".....at the Regional level, the Region will supervise health services at that level and below, including health care at the Regional Hospital, will also support the District on technical aspects and provide supervision being an extended arm of the Central Government"

Structurally, LGAs are under the Ministry of Local Government Administration but policies on health guidelines, standards and regulations for health services are prepared by Ministry of Health, interpreted by the region level while implementation and their adherence is done at the level of LGAs. No doubts along the route, aspects of implementation of plan lose steam from central government through LGAs and leave the people suffering the consequences in terms of service delivery

The study further observed that, Article 61(5) of the Constitution of United Republic of Tanzania and the Regional Administration Act Number 19 of 1997 give some overriding powers to the Regional Commissioners to intervene and interfere with the

autonomy of LGAs in Tanzania. This trend of affair cripples the efforts to ensure effective and efficient decentralisation for provision and improved health service delivery in rural Tanzania. **Figure 4.5** illustrates the structure of Government of Tanzania against which LGAs are expected to operate and improve public health service delivery to the people.

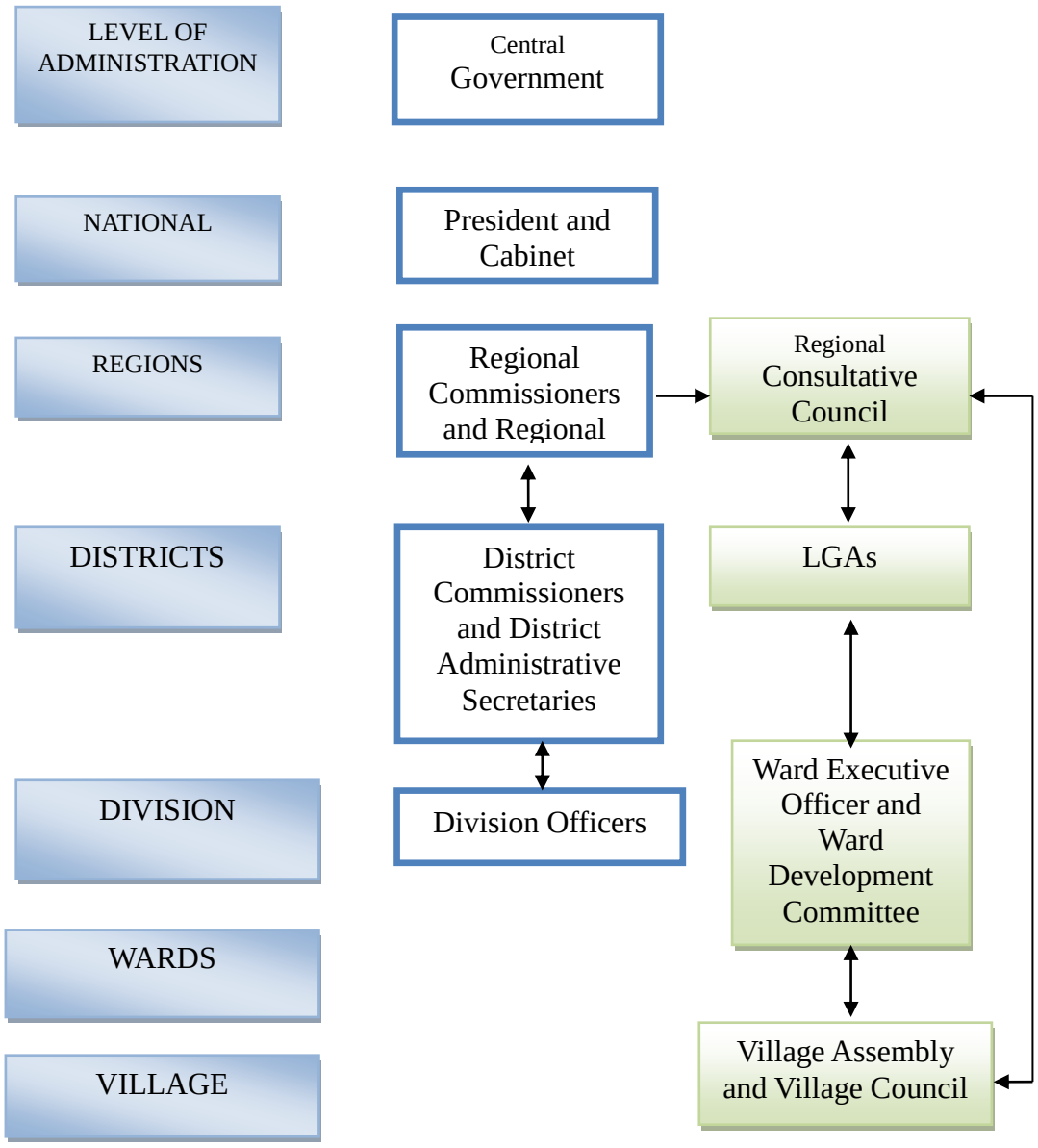


**Figure 4.5: Structure of Government of Tanzania**

Source, URT, 2015

Further analysis indicates that, decisions of LGAs in respect of health service delivery are presumed to be made by the people in their respective localities. However, the study analysis found that the plans and priorities in its originality seem to be inclusive and participatory but the implementation on the ground keeps changing even without prior consultation with the citizens and consequently belittle the role of decentralisation in health service delivery. This is implies that, the interplay relationship that exists between structural arrangement of government and powers vested in those structures has consequential effect for fruition of decentralisation initiatives in rural areas regarding health service delivery.

**4.4 Chapter Summary Conclusion**

This chapter examined the effects of institutional arrangement on decentralisation for improved health service delivery in rural Tanzania drawing experiences from the selected case studies of Pangani and Urambo. This chapter focused on two main issues. The first was an examination of respondent's social economic characteristics as extracted from questionnaires. The study was interested to examine the influence of those characteristics on decentralisation and service delivery. The study considered those social economic characteristics important especially when making an assessment on awareness about government policies, laws, systems and procedures related to decentralisation and the quest for improved public health service delivery in rural Tanzania.

The chapter also examined institutional characteristics and their effects on decentralisation and public health service delivery in rural Tanzania. Awareness of

service users under decentralisation policies and laws assessed and established. In addition, an assessment on the effect of policies and laws on decentralisation was made drawing perceptions from the user and provide sides. Finally, an examination on the government structure and its effect on decentralisation for improved public health service delivery.

The findings indicated that, generally from the two selected cases, social economic characteristics of the people had significant impact on the level of people's awareness about government policies and laws related to decentralisation as well as on the extent of access to public health service delivery. It became clear that people with low levels of education were not aware about decentralisation and pertaining laws and policies, the implication was that, they could not contribute to hold their leaders accountable on health service delivery. Similarly, they could not fully contribute to make informed choices as principals and agents in public health service delivery.

The study also established that economic background of respondents technically denied access to public health service delivery. Further, it was established that lack of facilities in most of the villages and wards necessitated users to travel some distances of which it required them to incur some costs. The cost-sharing element affects negatively those with low income who marginalised.

Regarding the institutional characteristics, it was revealed that, the nature, character and arrangement of policies, systems and structures negatively affected provision,

access and improvement of public health services through decentralisation strategy. The study established that, some of the laws and policies are in conflict with and retard efforts to improve public health service delivery. The management system and structure for health was revealed and seen complex and complicated with no clear demarcation of powers, roles and responsibilities among the key actors hence posing a problem with regard to principal and agents in service delivery. Power overlap among the key actors is another issue revealed by this study that affects negatively fruition of improved service delivery under decentralisation. The expected autonomy was low as central government has extraneous powers over LGAs in line with decentralisation principles. The study considers such state of happening affect the availability of health services and the level of responsiveness.

From the findings above, the study considers that, there is a detached relationship between the principles and promises of decentralisation on improving public health service delivery. The outcomes of the study on the ground show some discrepancies from the reform agenda and the hopes laid down by The National Health Policy and decentralisation policy. The mis match and discrepancy was evident by profound negative effect of institutional characteristics on public health service delivery with minimal if not dismal positive effects on improving access and quality public health service delivery.

The findings of the study through secondary information also established that the complicated legal and institutional set up and its nature results to shortage of human resource for health and other attendant medical related requirements for smooth

delivery of public health services. All these shortfalls affected the effectiveness of decentralisation for improved public health service delivery in rural areas. Therefore, from the above findings it is imperative to note that institutional characteristics and its subsequent policies, laws, systems, structures and operational procedures under this study undermined the effectiveness of decentralisation for improved public health service delivery in rural Tanzania. This is against the policy assumption that the established institutions would cultivate an enabling and conducive environment for decentralisation to bear fruition on public health service delivery to the people in rural Tanzania.

# CHAPTER FIVE

# 5.0 STATUS OF PUBLIC HEALTH SERVICE DELIVERY IN RURAL TANZANIA AFTER DECENTRALISATION

## 5.1 Introduction

The chapter focus was on the question whether the delivery of health services has improved after the decentralization reforms in rural Tanzania. It builds on specific objective number two and is based on empirical data collected through survey questionnaires, interviews, focus group discussions and analysis of secondary data.

The effectiveness of decentralization reforms on public health services was measured on the bases of access, quality and appropriateness for users of the services. The access of public health services was measured in terms of availability of health facilities, distance to the facilities, cost sharing arrangements and users' ability to pay for services. Other parameters of measure were in terms of availability of facilities such offices, beds and other equipments. In addition, accessibility of health services, quality of services, rule of law and human rights observance. Proper records keeping, Procedures for complaint handling, availability, competence and professionalism of medical staff, affordability of services were also determined.

The study tested customer satisfaction as a measure of quality, procedures to access services, availability of essential drugs and medicines, participation and accountability. In addition, the study tested perception on levels of corruption and other ill tendencies as well as general opinion on the effectiveness of decentralisation

reforms on health service delivery in rural areas from the two LGAs.

In order to describe the responses for the dependent variables under study, the study used descriptive statistics that were qualitatively analysed. According to Hair et al., (1998) it is important to reduce a large number of items to more manageable dimensions or underline constructs which would explain a large portion of variability among the various measures. In this study, the rating method (likert scale) was used to determine the status of public health service delivery and test whether the reforms have affected service delivery or not.

The rating method based on construct assumption statements. The respondents were required to respond using a 5- Point Likert Scale on a continuum ranging from **Strongly Disagree** to **Strongly Agree**. The responses to the construct statements focused to address the central question of this study.

In order to validate and compliment the primary information, the study deployed and complimented with secondary information through critical analysis of various reports and documents with material facts related to the study. In addition, the findings from interviews and observation from the respective Health Centres and Dispensaries in the selected LGAs (Urambo and Pangani) complimented to validate the findings. **Table 5.1** presents findings then followed by the analysis and discussions in a qualitative way to enrich the analysis hence draw conclusions that are more precise.

**Table 5.1: Responses on Status of Public Health Services Delivery (N=203)**

| Item/Parameter | Strongly Disagreed (%) | Disagree (%) | I dont know (%) | Agree (%) | Strongly Agree (%) |
|---|---|---|---|---|---|
| The public health centre/ dispensary is located within your village and is easily accessible | 33 (16.3) | 98 (48.3) | 7 (3.4) | 56 (27.6) | 9 (4.4) |
| The Health centre/dispensary has sufficient facilities for public health service provision | 45(22.2) | 94(46.3) | 31(15.3) | 31(15.3) | 2(1.0) |
| The distance to get public health services in your village is now shorter compared to the past ten years | 34(16.7) | 80(39.4) | 12(5.9) | 69(34.0) | 8(3.9) |
| The procedures to access health services in your area are fair and well known to the public. | 12(5.9) | 79(38.9) | 47(23.2) | 60(29.6) | 5(2.5) |
| The public health services in your area are promptly and delivered in time without unnecessary delays. | 21(10.3) | 94(46.3) | 20(9.9) | 63(31.0) | 5(2.5) |
| The Public health centre/dispensary in your area has sufficient essential drugs and medicines | 73(36.0) | 90(44.3) | 26(12.8) | 14(6.9) | 0 |
| The Public health Services in your area are provided responsively without corruption, nepotism or favouritism | 10(4.9) | 55(27.1) | 44(21.7) | 81(39.9) | 13(6.4) |
| There is citizens participation in decision making on key issues affecting public health in your area | 23(11.3) | 89(43.8) | 56(27.6) | 35(17.2) | 0 |
| The health sector employees in your area are accountable to the people | 9(4.4) | 61(30.0) | 50(24.6) | 78(38.4) | 5(2.5) |
| The Public health employees in your area are committed, Motivated and ready to serve the community. | 5(2.5) | 43(21.2) | 70(34.5) | 80(39.4) | 5(2.5) |
| The health sector employees in your area observe human rights, respect of law when serving the public. | 1(0.5) | 13(6.4) | 37(18.2) | 131(64.5) | 21(10.3) |

Source: Field Survey, 2015

### 5.1.1 Availability of Public Health Centre/ Dispensaries

The study under this sub theme undertook to determine whether health centres and dispensaries established near the people after decentralisation for easy access. The general respondent's opinion with regard to perception on availability of Health Centres and Dispensaries in the respective selected Local Government Authorities are summarised in Table 5.1.

The results indicated that 64.6 % of the respondents were not satisfied with the availability and access of health centres and dispensaries in the respective LGAs. Those who disagreed were 48.3 % and 16.3% strongly disagreed that health centres and dispensaries were located within their Wards or Villages respectively. However 27.6% of the respondents agreed and 4.4% strongly agreed that health centres and dispensaries were located within their Wards and Villages hence they were easily accessible by both men and women.

The aim of decentralisation was to improve the access and quality of public healthcare services and management capacity of local government authorities (LGAs) through construction, rehabilitation, extension and provision of equipments to health centres and dispensaries. The findings above imply that some of the villages have no health facilities and the services are not in their reach hence necessitating them to walk long distances to access services from the nearby villages. The policy intended to ensure that every ward and village has a health facility to facilitate access and availability of services. Through review of reports, which were made available to the researcher on the number of health facilities available in the

two Local Authorities the study established that at Urambo for example during the study period had fifteen (15) Wards but there was only one ward (Usoke) with a Health Centre . There were fifty nine (59) villages, but only twenty (20) Villages had Dispensaries. Pangani on the other hand had 14 Wards and 33 villages but there was only one (1) Health Centre at Mwera ward built by Germans in the 1950s to serve their workers in sisal plantation. Pangani had only sixteen villages (16) with Dispensaries out of 33 villages.

This situation defeats the objectives of the decentralisation policy and the National Health Policy, both of which categorically states that every village should have a Dispensary (D) and every ward should have a Health Centre (HC) in order to ensure that services are brought closer to people. The policy further proclaims that the health services shall be available and accessible to all the people in the country. Similarly, the Primary Health Services Development Programme (PHSDP) 2007-2017 launched in 2007 to "accelerate the provision of primary health care" within the framework of decentralisation, aimed at establishing a dispensary in every village and a health centre in every ward (URT, 2007).

The discussion in consideration of the findings established that, in some areas access to public health services was denied due unavailability conditions. This discouraged and denied users to access such services. Citizens had to travel long distances to the nearest village or ward to get health services. This also had some financial implication and time for the health service users contrary to the principles and objectives of decentralisation policy. This study considers that public health services

in rural Tanzania is still characterised by key obstacles, which include lack of facilities such as building for service provision, inadequate and unreliability features. The question about distance to health facility, the findings indicated that 55.8% of the respondents who participated were of the opinion that distance was still a bottleneck accessing public health services. Among them 16.4%, strongly disagreed and 39.4% disagree. On other hand, 37.9 had consideration that there are some improvements. From these respondents 34.0% agreed and 3.9% strongly agreed that there are some improvements. The findings from the opinions of service users indicated that distance to access health services still has some significantly impingement even after decentralisation. This implies that the status of health services in terms of availability and access per geographical coverage is still at remote. The FGDs supported the above findings. Comments like:

> "We are living very far from the dispensary where we get health services" (FGD at Mwera), "from here to our village where we come from is very far and when one gets sick at night, it is very difficult to get to the dispensary because it is far and transport reliability is a challenge" (FGD at Usoke)".

This also implies that decentralisation of public health service provision has not significantly reduced the distance to health facilities though there are some achievements, which cannot be ignored. Information from interviews with health employees and management teams from respective LGAs, Councillors and village chairpersons substantiated this position. In an interview with three-village leader who interviewed at different time and places at Mkalemo, Mkwaja and Kipumbwi respectively at Pangani they had this to say;

> "In our Local Authority the government has not been able to build dispensaries in every village. People travel distances of up to 10 Km to

> our village where we have a dispensary. Some get serious problems on the way to health centre or dispensary because even roads are not maintained regularly. Pregnant women are the most affected from the villages without dispensaries".

The study analysis indicated inter-village inequalities in the availability of health facilities. The average population served by most dispensaries exceeds the target of 5,000 as set out in the National health policy (URT, 2003, 2007). The most of dispensaries in Pangani and Urambo were serving a population of more than 5,000. The available dispensaries in the studied areas had a catchment of three to four villages to be served with a population of 7,000 and above. Consequently, these facilities had to serve many people, while they also experience critical shortages of staff, inadequate drugs, medical equipment and other supplies

Through documentary analysis, the study also indicated clearly that the number of health centres and dispensaries does not match the National Health policy requirements and decentralisation policy as well. **Figure 5.1** gives a summary of results from the field.

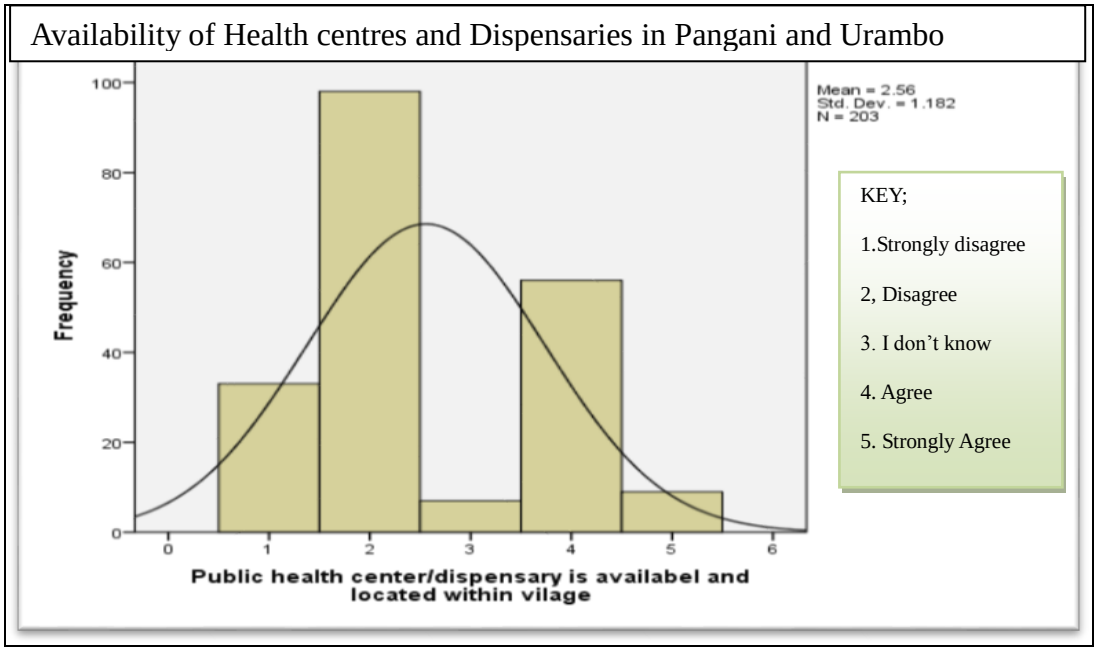


**Figure 5.1: Availability of Health centres and Dispensaries**

Source: Field Survey, 2015

### 5.1.2 Availability and adequacy of equipments for Service Provision

The respondent's opinion as per collected data showed that most of them were not satisfied with the availability and adequacy of equipments for service provision. About 22.2% of the respondents strongly disagreed and 46.3% disagreed on the issue of health centres to have sufficient facilities for service provision. Only 1% strongly supported and 15.3% agreed that health facilities had sufficient and adequate equipments for service provision. On the other hand, 15.3% were I dont know. This implies that decentralisation reforms had minimally achieved the intended objective of ensuring that buildings, office space, beds, delivery kits and other medical equipments are available for improved public health service delivery in rural areas. The National Health policy points out that availability of drugs, reagents and medical

supplies as well as infrastructures should be available to ensure that the policy vision and mission are achieved (URT, 2007).

The study established that, inequitable distribution of resources in Pangani and Urambo has led to inadequate infrastructure, poor management, underfunding and deterioration of existing facilities and hence compromised quality of healthcare. Similarly, the study through review of reports on human resource for health noted shortage of health workers in the respective LGAs. The analysis clearly established that health workers are consequently overburdened and working for longer hours. An interview with one midwife at Kigurusimba Dispensary in Pangani indicated the gravity of the situation in respect of inadequacy of health facilities and resources. She had this to say. I quote and translate;

> "....for almost six months now, the government has not supplied us with absorbent gauze, gloves and delivery pads. We advise and instruct them to these items themselves and come with such items. We are here to offer our technical skills but the supplies are not adequately available. As you can see the dispensary building is almost falling down and during rainy season the roof is leaking water every corner as you can see those patched holes on the roof...."

The researcher also observed how dilapidated existing health buildings which had never been rehabilitated. The dispensaries had no place to store medicines no space for consultation rooms and offices. Files for patient records were just scattered all over the floor and some hipped on a bed in one of the rooms. The study established further that medical supplies, equipments and infrastructures are inadequate in most of the public health facilities visited in the two selected LGAs leading to more or less poor service delivery, unnecessary suffering and even deaths of innocent citizens.

The focused group discussions revealed similar findings with regard to availability of equipments, office space, equipments and working tools. The results from focused groups at Msalaza Kigurusimba in Pangani and Usisya Usoke Urambo established that; distance, unreliable means of transport, lack of maternity waiting homes, lack of ambulance, lack of consultation rooms, insufficient medical equipment and essential drugs, delivery kits in health centres and other supplies as a critical bottleneck for improving health service delivery in rural areas.

An interview with councillors of Izimbili in Urambo and Bushiri in Pangani, on the issue of availability of medical equipments revealed that, inadequacy and lack of equipments stood as major bottlenecks in public health service delivery. They had this to say;

> 'Buildings for office space, delivery kits and maternity wards, essential equipments and transport facilities and medical supplies such as gloves and reagents are typically in poor state in our health centres contrary to the wish of the decentralisation".

The discussion and analysis of those findings revealed that these bottlenecks impair availability and deny access and right to health as well as quality of services offered by the respective LGAs. According to this study it was clear that public health facilities offer maternity services, but they lack essential equipments and medicines necessary to provide basic maternity services to women. This was supported by information obtained from focused group discussions at Msalaza, Kigurusimba and Usisya where one of the village leaders at Usisya pointed out that;

> "Sometimes health workers use candle or cellular phone torches at night to assist women in labour. In health centres fitted with electricity supply systems, power may not be available for lack of money to buy luku units. This may go for six months without electricity"

The study also through observation at Bushiri Dispensary indicated that some of the beds had no mattresses. This was made possible when one of the nurses took the researcher into one of the delivery and waiting room for women in labour. The room was in poor condition, the floor was full of cracks, walls had no paint and the facilities were not conducive to health service delivery. generally, the condition was too dirty as observed during field visits in the health facilities.

### 5.1.3 Affordability of Services and People's Capacity to Pay

The rationale for decentralization was to ensure that services are accessed and are of quality. Access as understood in the previous chapters encompasses availability of such services without denial. Also understanding access in line with the principal agency theory, the interplay entails services should be demand driven and not supply drive. The introduction of decentralisation for improved health care in Tanzania was expected to be in tandem with the introduction of cost sharing for health services. Cost sharing was introduced as part of the reforms and also to inform the people that social services have a cost. The plan also meant to generate revenues to improve the availability and quality of health services (Munishi, 2003; URT, 2003; Mamdani and Bangser, 2004; Kamuzora and Gilson, 2007). This section made analysis on the perceived affordability and people's capacity to pay on public health services from the selected LGAs.

The findings established that 12.8% of the respondents strongly disagreed whereas 55.7 disagreed that public health services provided by the respective LGAs were affordable. This implied and indicated that many people are not able to pay for health

services provided. However, 19.2% agreed and 5% strongly agreed that the services are affordable and they can manage to pay. The respondent's opinion are summarised in Figure **5.2.** The findings implied that the reforms had not influenced positively in this aspect if analyzed in isolation. Taking Pangani and Urambo as typical cases, there is still a problem with regard to the ability to pay for health services albeit through cost sharing. This is particularly applicable to rural areas as unit of analysis.

Interviewees in Pangani District alleged that, in some villages citizens had to travel about 15 Kilometres to get health services. If the people are to pay for that transport as well as for medical services, then it implied that there were added costs if this variable if is to be analysed with other items discussed especially on the issue of availability of health centres or dispensaries within villages and issue of distance. The findings from FGDs at Mwera came up with the following comments. I quote and translate;

> "some of us live very far from the dispensary where we get health services" (FGD participant from Mwera Ushongo village), "from here to the Health Centre is very far and when one gets sick at night, it is very challenging to get access to the Health Centre in time because we have no reliable means of transport. One must hire a motorcycle if capable to do so" (FGD participants at Usoke)

The analysis further showed that in rural Tanzania public health services often not easily accessed by the very poor. Such obstacles, which among others include, health care charges, long distances to facilities, inadequate and unaffordable and unreliable transport systems make health services provision a challenge. The study further observed that Cost sharing has not necessarily affected positively on quality

of health care. User fees were not the only charges citizens expected to pay; other costs include transport costs. Other unofficial costs including bribes, payments for drugs and supplies, and time spent away from productive activities that were particularly critical for people living in poverty.

The study revealed that, Health care charges placed an impossible financial burden on the poor families; many failed to access health care when they needed it most and some failed to obtain the necessary referral for more skilled care due to financial burden, which technically was attached to them. Nevertheless, as noted in the introduction part of this study, reforms are complex and expensive hence commitment and technical skills is very critical for the same to yield expected outcomes. **Figure 5.2** provides a picture on distribution of respondent's perception with regard to ability to pay and affordability of health services from the selected LGAs.

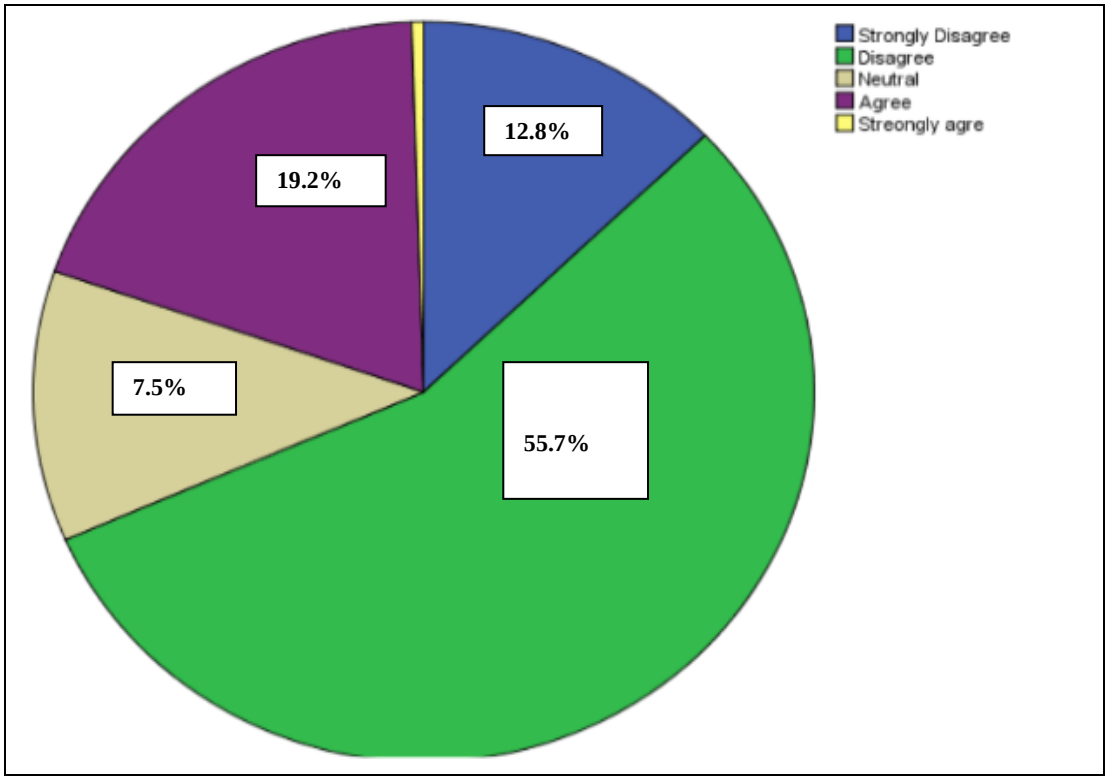


**Figure 5.2: Affordability and Ability to Pay for Health Services**

Source: Field Survey, 2015

The study endeavoured to know what people pay for when they visit health centres. Some of the respondents did not know what they paid for. Some indicated that they pay for check up and medicine. Among them 37.4 % indicated that that they did not know what they pay for. This is mainly due to low level of awareness as discussed in chapter four, which analysed social and economic characteristics of the respondents in the selected LGAs. Citizens did not always know what they were supposed to pay for whether legitimate or illegitimate. Some charges were official but not necessarily affordable, unofficial charges were still in place, and exemption, and waivers had not been very effective especially to pregnant women, children under five years and those of elderly age.

One member from the FGDs in Urambo had this to say;

> "Free health services for pregnant women and children I only hear it from politicians and radios. In our dispensary everybody pays. There is no free service. You have to buy gloves for your wife to deliver, you have to pay for medicine for your children and even visiting the health centre, needs money for transport, so what do you mean by free medical services? He concluded"

The study established that some of the people in rural areas due economic crippled situation were forced to sell their livestock in order to pay basic services. This situation integrates them into a vicious circle of abject poverty. Some appeared for medical attention very late when they were critically ill and consequentially with fatal conditions causing their death. The study also established through the interviewees that, some of the citizens as a solution to run away from those costs from conventional treatments they opt for traditional treatment, which significantly affects them. **Table 5.2** gives an illustrative scenario from respondents what do they pay for and who determines the payments.

**Table 5.2: Objectives of payments N=203)**

| What do you pay for | Number | Percentage |
|---|---|---|
| Registration | 15 | 7.4 |
| Check up | 6 | 3.0 |
| Service charges | 17 | 8.4 |
| Drugs/Medicine | 51 | 25.1 |
| Check up and medicine | 29 | 14.3 |
| Diagnostic | 9 | 4.4 |
| Don't know | 76 | 37.4 |

**Who determine the amount to be paid for public health services (N=203)**

| Who determine the payments | Number | Percentage |
|---|---|---|
| Health providers | 82 | 40.4 |
| Government | 37 | 18.2 |
| Council members | 16 | 7.9 |
| Don't know | 68 | 33.5 |

Source: Field Survey, 2015

### 5.1.4 Availability of health Workers in LGAs in Tanzania

The decentralisation reforms and National health policy among other issues intended to transform and build LGAs into coherent and strong institutions with competent and performing human resource for health (URT, 1998; 2003; 2007). The theoretical and conceptual framework of this study recognises human resource for health as important parameter for decentralisation to yield the expected results. In view of the above the study collected data on availability, competence and preparedness of human resource for health in the selected LGAs. This was one of the key factors in improving public health delivery. Access to public health and quality also is tested against the availability, competence and preparedness of service providers.

The views of the respondents are as indicated in **Table 5.3.** The respondents involved in this study were not very much satisfied with the availability of health workers in their Local Governments. The findings indicated that, 12.8% strongly disagreed and 33.5 % disagreed that health personnel were available while 33% agreed and 3% strongly agreed that the staff were competent and available signifying that there were some improvements. This implies that the decentralisation reforms had not contributed much in this area though there are some achievements noted. The **Table 5.3** summarizes the results.

**Table 5.3 Availability and adequacy of health workers in LGAs in Tanzania**

| Scale | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| | Strongly Disagree | 26 | 12.8 | 12.8 |
| | Disagree | 68 | 33.5 | 33.5 |
| | I don't know | 36 | 17.7 | 17.7 |
| | Agree | 67 | 33.0 | 33.0 |
| | Strongly Agree | 6 | 3.0 | 3.0 |
| | **Total** | **203** | **100.0** | **100.0** |

Source: Field Survey, 2015

Through interview, the study established that there was critical shortage of medical staff in all the two LGAs where the study was conducted. In the interview with the officers responsible for health personnel in the respective LGAs it became clear that, Pangani LGA had only one Health centre at Mwera, but the staffing issue indicated shortages as per establishment level. The shortage ranged from Medical Doctors, nurses and other professional staff needed by the health Centre. Through review of documents, the study found that, the requirement of health workers of different categories for Mwera Health centre as per National health policy guideline was 35 employees. The actual available number was 16 (47%) staff only. The deficit was 19 health workers, which is equivalent to 53%. In the dispensaries visited, they had only two (2) or three (3) staff instead of five (5) as per Councils establishment and National Health Policy requirement (URT, 2015).

Similarly, at Urambo LGA the situation was the same. There was only one health centre at Usoke, the staffing for medical staff was also not sufficient as per establishment. The requirement was 35 staff for that Health Centre but during the study only 11 (31.4%) staff were available, leaving a deficit of about 79.6%. The analysis in the human resource for health report for Urambo indicated a shortage of 44 health employees for dispensaries and health centres for the whole Local Government Authority. At the District level, health staff for the District Hospital, Health Centres and Dispensaries the shortage for Urambo stood at -226 medical staff against the required number of 463 medical staff hence the whole district had only 237 medical staff available during the study period.

A point of interest was the fact that, Usoke Health Centre at Urambo had a requirement of one driver for an ambulance and there was no driver at all. One would be interested to know if there was no driver do they real have an Ambulance for emergency and referral cases? In addition, there was no Mortuary attendant although the mortally was there, Pharmacist dispensing medicines, Lab Technician and Medical Records Management Assistant to manage records for patients and other key records for the health centre were not available. It is very difficult to track patient's records in the absence of records personnel with requisite knowledge and skills.

This connotes that access, quality, reliability, sufficiency, dependability and availability of health services in those LGAs was questionable with scant positive affect because of implementing decentralisation policy. Through secondary information the study established that in 2012 the Ministry of Health and Social Welfare (MoHSW) reported a shortage of about 113,000 health workers for the nation. The available number of health workers was 64,500 only to serve a population of over forty million Tanzanians (URT, 2012 and 2013). The analysis further established that 69% of medical doctors were working in urban areas hence leaving the rural areas understaffed with only 31% of the required staffing to over 70% of the nation's population. This study considers the situation consequential to health status of rural citizens and impairing the access and quality of health services in rural areas.

The study further examined documents on Human Resources for Health (HRH) to

determine the status of public health. It established that, there was a crisis which has grown into a common phenomenon in the health sector, mainly associated with maternal deaths. The study also clearly established that the crisis of Human Resource for Health was recognized and recorded as one of the major stumbling block for achieving the Millennium Development Goals (MDGs), particularly those related to maternal and child health (URT, 2013).

The issue of shortage of health workers was further affirmed by the study when respondents were asked whether the health services meet expected or perceived quality standards. They asserted that, they were not satisfied with services offered to them by public health facilities in their respective areas. The respondents who were involved in the study, 54.7% disagreed and 13.8% strongly disagreed on the issue of quality and standards of public health services. A few of them 16.7% agreed that services are of quality and meet expectations and satisfaction of users. In an interview with service providers, they pointed out that quality was a challenge. The quality expectations of service users was below average due to multiple challenges facing the health sector in the rural areas. The challenges include shortage of facilities, shortage of health workers, low morale of employees, delayed supply of essential drugs and medical supplies, poor working and service delivery conditions and environment. **Figure 5.3** indicates the views of service users about the quality and standards of services they receive.

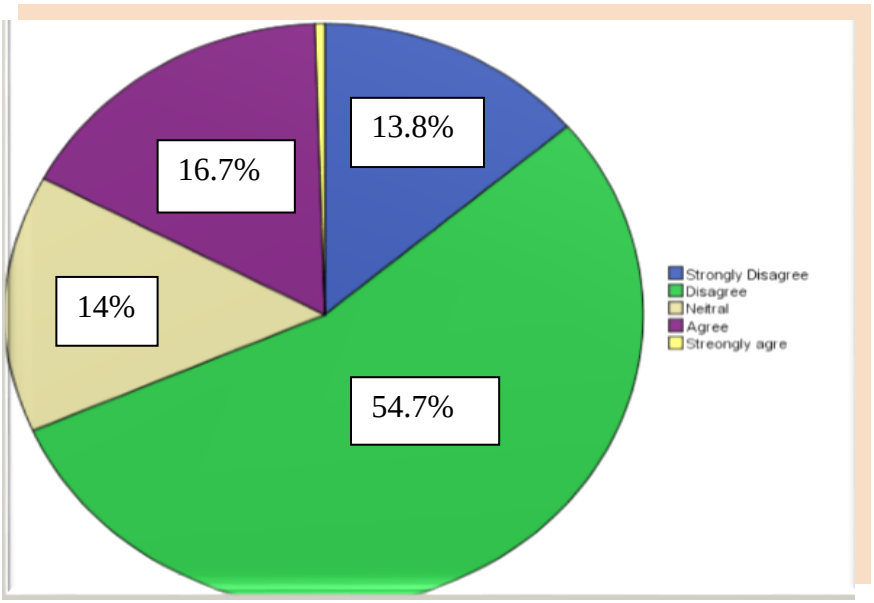


**Figure 5.3: Perception on Quality of Health Services**

Source: Field Survey, 2015

### 5.1.5 Customer Handling for Public Health Service

The commitment and preparedness of health service providers was measured through analysis of the institutional mechanisms that include structures and procedures for customer handling. The theoretical and conceptual framework provides that decentralisation as an institutional reform, operates within defined structures and procedures. It is also a fact that, Citizen demand on quality, quantity, economy openness on procedures, rights and duties and timely service delivery from public institutions has become a norm and obvious phenomenon (Hussein, 2015). In this regard, data collected mainly in customer handling by service providers in order to determine staff conduct and behaviour in receiving, listening and treating patients. The analysis was made to test the effect of customer handling mechanisms by service providers on the status of public health service delivery in rural Tanzania drawing experiences from Pangani and Urambo.

The respondent's views as indicated in **Figure 5.4** show that those involved in this study were not aware about procedures for handling patients. The study established that 38.9% disagreed, 5.9% strongly disagreed, and 23.2% were I don't know. The study suggests that even those who were I dont know were likely to be not aware and that was why they were undecided. A small proportion of the respondents namely 29.6% agreed and 2.5% strongly agreed that procedures for accessing and handling of customers were fair well known to service users.

The analysis from the findings indicated and imply that, the people were not aware with the customer grievance handling procedures in the respective LGAs. Through interview, the Management staff from the two LGAs admitted that they had not yet developed the service charters to articulates procedures for accessing services and outlining duties and responsibilities for both parties (supply and demand side). Interviews with departments responsible for Human Resource Management, indicated that no seminars had been organised on customer care and service management for medical staff. Such seminars had not been organised due to lack of budgetary provision for the activity.

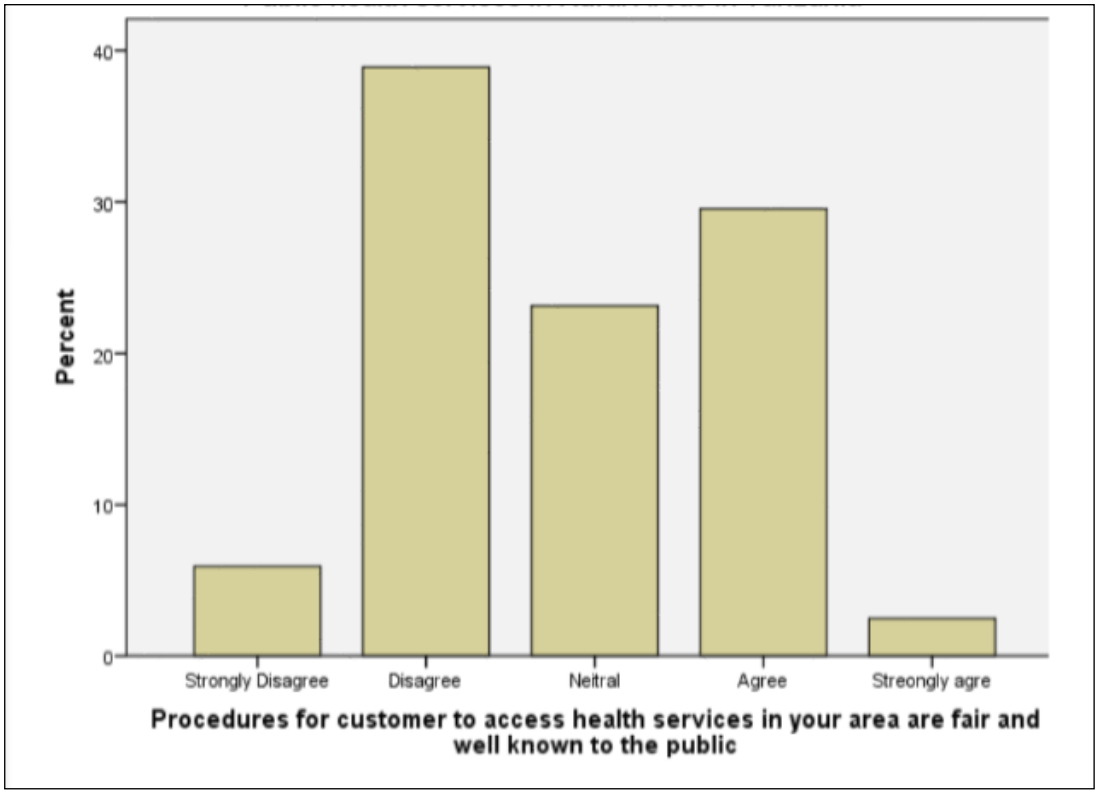


**Figure 5.4: Customer handling procedures**

Source: Field Survey, 2015

Data from this study was analysed and discussed in line with the principal agency theory. It confirmed that, citizens were no longer passive and inactive subjects in the society and should not remain under estimated. Noting this assumption, this study therefore considered the issue of openness on customer grievances handling procedures as critical in determining the quantity and quality of health services and its subsequent status in rural Tanzania.

The study found that, LGAs reforms among other things emphasised institutionalisation of Client Service Charters as one among the many tools of

managing performance and service delivery in public institutions. At the time of this study, observation could not establish any means and mechanism available for citizens to report grievances or positive comments on the conditions of services offered in those facilities. Suggestion boxes or cellular phone numbers were not available for people to direct their dissatisfaction or appreciation on the services received.

The service charter describes all the services the institutions offers, their standards, time for processing a service, duties and responsibilities for both client and the institutions. It also sets out feedback mechanisms including a system of handling public complaints. The charter developed in consultation with clients using the assumption of reciprocity under the agency theory. Staff and stakeholders that continually grow with an institution also should be involved. Above all Client Service Charters (CSCs) aims at improving efficiency and effective service delivery in terms of quality, quantity and Economy.

Results of data analysis has revealed that, public institutions need to change their approach of serving the public as abstract and passive subjects hence treating the same as recognizable and as respectable actors, capable of influencing policies, processes and making public institutions more responsive to the citizenry needs, demands and concerns. In so doing, the essence of principal agency relationship under would be meaningful and realistic.

The study established that, there was solid and compelling evidence that where procedures are clear and well known, the users get to know what to expect from the health providers and the latter should provide. Where procedures are unclear, health staff can change things and the people have no option but to accept what is offered even at a price. Therefore, clear and well known procedures influences users to access health services, where procedures and communication mechanisms were not well known to clients there was an adverse effect on initial access to health services and its subsequent quality.

The consequence of institutions failing to institutionalise service charters which outline procedures for service delivery and timeframe for services entails services are likely to be delayed and citizens cannot be timely served hence impairing responsiveness of health services. **Table 5.4** summarises the perceptions of respondents through questionnaire from the users (demand) side on timeliness of services offered in their rural setting after decentralisation.

**Table 5.4 Responsiveness and Timeliness of Service Delivery**

| Scale | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| | Strongly Disagree | 21 | 10.3 | 10.3 |
| | Disagree | 94 | 46.3 | 46.3 |
| | I don't know | 20 | 9.9 | 9.9 |
| | Agree | 63 | 31.0 | 31.0 |
| | Strongly agree | 5 | 2.5 | 2.5 |
| | **Total** | **203** | **100.0** | **100.0** |

Source Field Survey, 2015

Through interview with one of the key informant from Urambo LGA who was a village leader had this to say; Quoted and translated;

> "Delay of service delivery in health centres is due to shortage of staff, facilities, space for service provision and distance for citizens to access services."

Nevertheless, the study also sought to establish the views from the supply (provider) side who generally indicated that, the situation was moderately fair. The study also sought to establish levels of corruption and nepotism in public health service delivery. The study made reference to Transparency International (2014 and 2015) using a corruption Index, Tanzania was ranked as 119 for 2014 and 117 for 2015 with a score of 31/100 for 2014 and 30-39 scale for 2015. The views from the demand side indicated that, there were some improvement whereas 39.9% agreed and 6.4% strongly agreed. The remaining, 27.1% disagreed, 4.9% strongly disagreed and 21.7% were I dont know. The analysis indicates that though there were some improvements but still elements of corruption, nepotism and favouritism still existed in health service delivery system in rural Tanzania.

This indicated that there were still corrupt practices, despite government's commitment to mitigate if not eradicate the vice. Corruption undermines the service delivery strategies and retards economic progress and growth of democratic values of openness and accountability in the use of public resources and health service delivery. **Table 5.1** has a summary of findings on the people"s views on the level of corruption and nepotism in health service delivery in rural Tanzania.

Empirical evidence on corruption indicates that there is a relationship between corruption and health service delivery. Corruption in health service management and

delivery affects access and quality as well as denies the poor the right to health Bossert (2014) and Cockroft (2014) in Rispel et al., (2015). The findings and discussions revealed and established that, there was little achievements in these areas at grassroots as it was outlined in the LGAs reforms and decentralisation for improved public health in particular. The problem was multifaceted by the fact that citizens in rural areas where the study was carried out most of them had low level of awareness on policies, laws, guidelines that are pre requisite conditions for effective decentralisation and its resultant outcomes.

### 5.1.6 People's Perception on Availability of Essential Drugs/ Medicines

The World Health Organisation and The National Health Policy 2007 sets standards for quality of health services, which include availability of medicines and drugs in health centres. The study inquired to test the effect of decentralisation on the availability of essential drugs and medicines in rural health centres as a measure of performance for access and quality of health service delivery in the selected LGAs.

The results presented in **Table 5.5** indicated that, the respondents who were involved in this study were of the view that drugs and medicines in public health facilities were not adequately available to suffice the needs of users. The findings were clear that 36.0% strongly disagreed and 44.3% disagreed on the issue of availability and adequacy of essential drugs to meet the need of the public. On the other hand, 12.8% were I don't know and 6.9% of the total respondents from the user side agreed that essential drugs and medicines were adequately available. The findings imply that, the local government reforms initiatives and particularly decentralisation had minimal effect on the thrust to improve availability of drugs and medicines. Lack of

basic medical material and equipment was an important constraint to access and quality of health care services. This connotes that, the shortage of essential medicines and drugs negates efforts to improve public health services and the state of people's health. The respondents were asked to indicate whether they agree that drugs and medicines were adequately available in their health centres. Table 5.5 show their level of agreement and disagreement.

**Table 5.5 Availability of essential Drugs and Medicines**

| Scale | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Strongly Disagree | 73 | 36.0 | 36.0 |
| | Disagree | 90 | 44.3 | 44.3 |
| | I don't know | 26 | 12.8 | 12.8 |
| | Agree | 14 | 6.9 | 6.9 |
| | **Total** | **203** | **100.0** | **100.0** |

Source: Field survey, 2015

The views from the user side above, further supported by the position of respondents from the supply side. From the supply side, the study established that 90% of the respondents who were the health workers in the visited facilities indicated concerns on critical shortage of essential drugs and medicines as well as other medical supplies such as delivery kits for pregnant women, gauze, gloves, reagents and laboratory material. **Figure 5.5** gives a picture from the supply side.

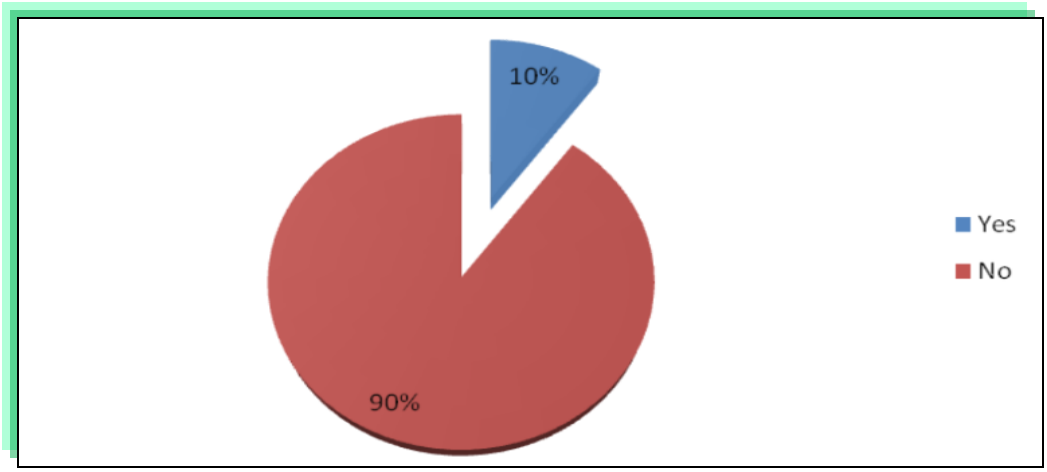


**Figure 5.5: Availability of essential Drugs and Medicines (N=20)**

Source: Field Survey, 2015

The study also through interview with key informants responsible for Health management at District level at Pangani LGA, established that shortage of drugs and other medical supplies was a problem and was caused by unnecessary bureaucracy and flaws in the system of ordering the supplies. In an interview, the respondent had this to say, I quote;

> "There is a problem with the ordering schedules from Medical Stores Department, delay of funds and cumbersome procurement procedures leading shortage of drugs and other medical supplies in our health centres. The ordering system is not clear and we are often discouraged in our work. You do your work but others who are in other institutions do not compliment on your efforts to facilitate smooth service delivery"

The study further made a review and analysis of secondary information to triangulate the information, add on the credibility, and validate primary findings from the field. The study established that the governance of health care in Tanzania largely was decentralized since 1998 (Macha et al, 2011). The system broadly classed into three functional administrative levels - district, regional and national (URT 2009). This implies that there was a communication and coordination problem caused by institutional set up and management of health sector system in the country, which

deters the essence of decentralisation of ensuring availability of drugs, medicines and other medical supplies on time and responsively.

The study also made a review on the findings of the Controller and Auditor General (CAG) Audit report for Financial Year 2010/11 in relation to the health sector. The study established a series of shortfalls, which point to failings in the procurement and distribution system of drugs and other medical supplies in Tanzania. The report indicated that Drugs and medicines worth eight billion Tanzanian shillings expired while stored at The Medical Stores Department (MSD) while health centres and dispensaries in rural areas were experiencing acute shortages of the essential drugs and other supplies (URT, 2011).

Through analysis of questions raised by Members of Parliament (MPs) with regard to medicines and medical supplies in health centres for the financial years 2007/08, 2008/09, and 2010/11 the study established that, drug availability issue, was a matter of concern and public interest (**See Table 5.6**). The questions were centred around the same theme about poor supply and unavailability of essential drugs, medicines and medical supplies at health facilities throughout the country and particularly in rural areas.

**Table 5.6 Questions by Members of Parliament (MPs) on medicines and Medical supplies for Financial Years 2007/08, 2008/09 and 2010/11**

| | **2007/2008** | **2008/2009** | **2010/2011** |
|---|---|---|---|
| Number of questions from MPs | 124 | 165 | 99 |
| Questions on medicines and medical supplies | 62 | 79 | 49 |
| Number of MPs who raised questions | 47 | 43 | 38 |
| % of MPs who contributed to issues of medicines and medical supplies | 37.9 | 26.1 | 38.4 |

Source: Field Review, 2015

The data in the table above, clearly establishes that the health sector in rural areas was a matter of concern and was still farfetched despite initiatives taken to decentralize with intent to ensuring that availability, reliability, sufficiency, dependability and access is improved. In this regard, the study established that there had been insignificant positive effect on the state of health service delivery on drugs and medicines availability resulting from decentralisation in rural Tanzania.

### 5.1.7 Compliance to Rules, Motivation and Commitment of Health Workers

Decentralisation reforms aimed at improving service delivery by ensuring that there is respect of law, human rights and dignity when serving the public. The assumption was that, all public servants observe the rule of law, human rights and dignity. The 2000 World Health Organization Report introduced the concept of stewardship as the most fundamental function of a health system. This makes possible and ensures the attainment of the health system goals namely; improving and promoting people's health; ensuring responsive and quality health service delivery and protecting citizens against the financial costs of illness (WHO, 2000). The responses from the demand side were as summarized and presented in **Tables 5.7, 5.8 and 5.9** The

respondents who were involved in this study from the respective LGAs indicated that there were some improvements in this area. Public servants and particularly health workers in the selected cases did uphold dignity and humanity while serving the citizens. In addition, their level of readiness and commitment to serve recorded some improvements with regard to public health service delivery. The issue of accountability had scanty achievements to record. Lack of awareness on governance resulted to some of the respondents to remain undecided taking a I dont know position. This can be traced back in chapter four where it was clear that majority of the respondents were having primary education of which the study considered the same to affect their ability to understand governance issues and hence failing to hold leaders and public servants accountable for what they are deciding.

**Table 5.7: Readiness of Health Workers to Serve the Community**

| | | Frequency | Valid Percent | Cumulative Percent | |
|---|---|---|---|---|---|
| Valid | Strongly Disagree | 5 | 2.5 | 2.5 | 2.5 |
| | Disagree | 43 | 21.2 | 21.2 | 23.6 |
| | I don't know | 70 | 34.5 | 34.5 | 58.1 |
| | Agree | 80 | 39.4 | 39.4 | 97.5 |
| | Strongly agree | 5 | 2.5 | 2.5 | 100.0 |
| | **Total** | **203** | **100.0** | **100.0** | |

**Table 5.8: The Health Sector Employees Accountability to the People**

| | | | | | |
|---|---|---|---|---|---|
| Valid | Strongly Disagree | 9 | 4.4 | 4.4 | 4.4 |
| | Disagree | 61 | 30.0 | 30.0 | 34.5 |
| | I don't know | 50 | 24.6 | 24.6 | 59.1 |
| | Agree | 78 | 38.4 | 38.4 | 97.5 |
| | Strongly agree | 5 | 2.5 | 2.5 | 100.0 |
| | **Total** | **203** | **100.0** | **100.0** | |

**Table 5.9: Respect of Law Dignity and Human Rights and Dignity by Health Employees**

| | | | | | |
|---|---|---|---|---|---|
| Valid | Strongly Disagree | 1 | .5 | .5 | .5 |
| | Disagree | 13 | 6.4 | 6.4 | 6.9 |
| | I don't know | 37 | 18.2 | 18.2 | 25.1 |
| | Agree | 131 | 64.5 | 64.5 | 89.7 |
| | Strongly agree | 21 | 10.3 | 10.3 | 100.0 |
| | **Total** | **203** | **100.0** | **100.0** | |

Source: Field Survey, 2015

The findings above imply that decentralisation significantly contributed towards institutionalization of culture on respect of law, observing dignity and human rights in service delivery in Local Authorities. **Table 5.9** indicated that 64.5% respondents agreed and 10.3% strongly agreed that health workers observe and adhere to the laws, dignity and human rights.

The respondents indicated that health workers were moderately committed to serve the citizens. The results in **Table 5.7** indicated that 39.4 % agreed and 2.5% strongly agreed that health workers were committed and were redy to serve the people in the selected LGAs. The puzzle is that about 34.5% of the total respondents were I dont know. The study considered that, level of education majority of the respondents contributed for some receive services without judging the issue of readiness and commitment. The study also established that, the challenge was on motivational issues such as lack of housing in rural areas that resulted to some health workers to seek for transfer so that can be deployed in other places, which were relatively developed. Through interviews with two key informants from the two LGAs who were leaders from Izimbili in Urambo and Kigurusimba at Pangani had this to say; quoted and translated;

> "In our areas we live in ordinary and low quality houses. When health workers are posted to work in our village the first thing that disappoints them is the issue of accommodation. The health facility has no houses for them. As a result they hardly stay for a week then ask for permission that they are going back to mobilise themselves to effectively start working. Once they go, most of them do not return to their work station back again"

Through secondary information, the study established that, improving the motivation of front-line clinical staff even through non-monetary rewards such as mentoring and capacity development support can have significant effect on the quality of local health services. Observations from the field (based on the authors' experiences) suggest that it is de-motivating for a health professional when he or she is required to deliver health services without adequate tools and resources.

On the issue of accountability, the study established from respondents that health workers were relatively accountable to the citizens and they treated and handled them with humanity despite the poor working conditions for service delivery. The respondents views indicated that 38.4% of the total respondent agreed and 2.5% strongly agreed that health workers are accountable to the people. On the other hand 30.0% disagreed and 4.4 % strongly disagreed that health workers were not accountable to the people. The findings imply that decentralisation strides had some achievements though not celebrated to its full notch.

This also confirms the assumption in the guiding theories for the study that LGAs reforms aimed at improving service delivery by ensuring that there is institutionalization of the culture of transparency and of giving feed back to

stakeholders on service delivery in all public sector institutions. The assumption that public servants are transparent, accountable and often give feedback to stake holders on service delivery remains valid for health service under decentralisation. **Table 5.8** provides a summary on the views of respondents.

### 5.1.8 Perceived Effect of Decentralisation on Public Health Service Delivery in Rural Tanzania

Decentralisation reforms generally aimed at improving service delivery including public health services. The assumption that the reforms were adopted, implemented for improved service delivery under this study has no dispute. The general responses from both demand side and supply side as well as from documentary reviews indicated that decentralisation had been implemented and there were some few improvements to note. **Table 5.10** summarizes the findings from the demand or user side where 45.3% agreed that decentralisation has improved health service delivery in rural Tanzania. 24.6% disagreed and 30% said they Don't know.

The findings implies that, decentralisation reforms were not fully fledged for fruition of expected results. However, without going into specific aspects and analysing them in isolation, decentralisation has slightly contributed positively the general health service delivery in rural Tanzania. The effect is in terms of increased number of dispensaries, readiness of health workers to serve the public and number of health workers. Moreover, a number of issues that needs attention of which the findings and discussions of the study revealed. Nonetheless, in its generality the study has established clearly that decentralisation reforms have been adopted and implemented

with scanty positive effect on public health service delivery improvements in rural Tanzania. This study acknowledges the fact that decentralisation as a policy action and strategy cannot bring changes overnight. It is a gradual process of which its effect and direct outcomes takes time to be realised.

**Table 5.10: General perception on the effectiveness of Decentralisation on public health service delivery (N=203)**

| **In your opinion do you think Decentralisation in had any positive effects on health service delivery in local authorities?** | **Number** | **Percentage** |
|---|---|---|
| Yes | 92 | 45.3 |
| No | 50 | 24.6 |
| Don't know | 61 | 30.0 |

Source; Field survey, 2015

### 5.1.9 Challenges affecting improved Public Health Service Delivery.

This section addresses the third specific objective of the study. One of the specific objectives of the study was to identify and analyse the challenges affecting effective implementation of decentralisation for improved public health service delivery in Local Authorities in Rural Tanzania.

In order to analyse the challenges respondents from both demand and supply side were asked to identify key challenges that affect the smooth implementation of decentralisation particularly for health sector. The health workers were considered key players in the drive and implementation of the decentralisation reforms in public service specifically health sector in Tanzania. The user side were the direct beneficiaries of the outcomes and effectiveness of decentralisation reforms.

Literature has indicated that challenges in decentralised local government authorities in Tanzania were multi-faceted and integrated in character. They comprise policy-induced challenges; skill, task and organization induced challenges and performance motivation induced challenges. To be more specific they include Low job satisfaction due to poor working conditions, low salaries, inadequate funds for training and development, and unequal training and development opportunities for all employees (Issa, 2011 and Hussein, 2015).

Findings from questionnaires, interviews, secondary information, focused group discussion and observation the study indicated that most of the challenges were centred on availability, accessibility, availability of facilities, availability of drugs and other resources. The challenges included; Reluctance to changes especially mind set to some employees to accept changes. Fear of changes affected the smooth implementation of decentralisation for service delivery.

Poor working conditions for health workers negatively affected decentralisation and posed a critical challenge on motivation and retention of health workers and the subsequent service delivery to the public. Inadequate facilities (such as offices and equipments) also posed challenges on the quality of health care provided. Inadequate medical supplies and public health facilities and lack of exemptions for cost sharing in health services were some of the extra challenges.

Inadequacy of essential drugs and medicines, delayed allocation of resources formed serious challenges, which impaired availability, access and quality of health

care and the ultimate expected outcomes of decentralisation policy on the ground. Unpreparedness of public servants to implement reforms was another challenge. Analysis of secondary information and responses from interview with key respondents indicated that the reforms agenda was not homegrown hence lacked ownership. Issa (2011) noted that LGAs reforms had too much dependency on donor funds hence its sustainability was very uncertain. Pallangyo (2009) also found that lack of human resource capacity in LGAs affected and posed a challenge on effective implementation of decentralisation reforms.

Other challenges includes low levels of awareness on the reforms particularly policies, laws and procedures, Lack of ownership on reforms by some stake holders due to poor participation, Lack of political will and commitment on reforms from some top leadership positions , Inadequate staffing levels in health, Corruption and greed behaviour to some health employees.

Other challenges were, weak legal framework to address corruption and poor customer focus culture to some public employees, lack of accountability, distance to access health services, and housing for health workers and costs of health services.

All these challenges together and collectively affect fruition of decentralisation and its effectiveness on public health service delivery. The responses from the questionnaires with open-ended questions were read and re read to get constructs in themes that are meaningful. After that the themes were grouped and coded to reduced themes for easy presentation as indicated in **Table 5.11**.

**Table 5.11: Challenges affecting implementation of decentralisation of health services delivery in LGAs**

| Challenges | Number | Percent |
|---|---|---|
| Unnecessary bureaucracy | 17 | 8.4 |
| Lack of facilities and medical supply | 37 | 18.2 |
| Insufficient drugs and medicine | 74 | 36.5 |
| Shortage of health workers | 28 | 13.8 |
| Corruption and non responsiveness for health workers | 29 | 14.3 |
| Poor working conditions | 4 | 2.0 |
| Cost of medical services | 13 | 6.4 |
| Don't know | 1 | .5 |
| Total | 203 | 100.0 |

Source: Field Survey, 2015

Additional challenges were extracted from the senior Council management team who also pointed out that reforms have depended mainly on donor funds of which they were pessimistic that sustainability of few notable achievements as a result of decentralisation reforms are likely to fail after donors withdrawal.

The respondents further pointed out that funds from donors normally had a smooth flow for projects being funded by donors, but government subvention was a problem. The study also established that cumbersome and prolonged chain in the procurement of medical supplies was a critical challenge.

Communication and coordination within and outside the study established it as challenge imbedded in systems and structures of health sector management in Tanzania. The systemic, structural and practical arrangements of the health sector administration in Tanzania are also a major challenge. The responsibilities among

various actors are not very clear thereby affecting smooth decentralisation for improved public health service delivery in rural Tanzania.

The study through interviews with dispensary staff, however, found that health facilities experienced frequent and sometimes prolonged shortage of drugs due to delayed delivery of drugs from the MSD. In some cases, the dispensaries received drugs that had not been requested. This implies that there ordering schedule and circle is not well defined.

The implication of all these challenges affected the decentralisation as a process and policy action. Additionally those challenges inherently affected the intended outcome and impact of decentralisation in terms of availability, accessibility, quantity, quality and affordability of public health services in rural Tanzania.

### 5.1.10 Chapter Summary and conclusion

This chapter determined the status of public health service delivery under decentralization reforms drawing experiences from Pangani and Urambo. The focus was on the access, quality and appropriateness of health services. In this chapter, the findings of the study were presented, analysed and discussed using some aspects and determinants of service delivery under decentralisation reforms as used in the theoretical and conceptual framework.

The chapter measured and examined the status of rural health services using specified determinants which included availability of health facilities, availability of equipments and buildings, distance to get health care, availability of equipments, availability of health workers, procedures for customer and complain handling,

responsiveness and timeliness and availability of essential drugs. In terms of access, it is evident from our findings that decentralization reforms have minimally contributed to increasing the availability of health facilities, particularly construction of few dispensaries, thereby raising the service coverage in the two selected LGAs.

From the findings it was clear that the management and administration of healthcare services has been decentralized to LGAs. However, the facts on the ground are different with regard to facilities such as buildings, office space and working tools. The efficacy of decentralisation in rural areas is farfetched. The building are not in good condition as revealed in Pangani at Mwera and Kigurusimba. In Urambo at Usoke health centre and Usisya the buildings were not in good condition. Working tools do not match the expectations of delivering quality services in the studied LGAs. This situation from the study analysis and discussion was a result of controls from the centre over the 'technical quality' of the health infrastructure and services, which sometimes conflicts with local initiatives. In addition, there is still inadequate infrastructure to provide full primary healthcare coverage in all villages and wards as per National health policy. This stood as a major obstacle for many users who had to travel considerable distances to access healthcare.

The findings further indicated that although cost sharing measures were intended to complement government financing so as to improve the quality of services, they also stand as an obstacle to access healthcare for the rural poor. The costs do not cover for health services per se but also they included travelling costs whereby the rural poor who are very conscious to healthcare costs, are at risk of exclusion due to the

inability to pay. The study findings on the issue of capacity to pay indicated that majority of the respondents could not afford the cost for medication and other associated costs. The study considers this to be regressive and inequitable, and can lead to decreased utilization of health services among the poor. In the study the exemption rules were not effectively implemented and in fact had negative impact on access to health services for such groups especially the poor families, hence reinforcing existing inequalities.

The study was also able to establish critical shortage of human resources in health facilities. The shortage of health workers as established by this study it is considered to have a profound effect on the quality of public health services provided as a public good. The study considers that, this technically breed exclusion among users.

With regard to perceived quality by the users, the findings indicated that the reforms have focused mostly on building and rehabilitation of health facilities but that less has been achieved in other respects, such as adequate staffing and availability of drugs and other essential supplies. It is worth to note that, the users are not only concerned with the availability of facilities, but also about the quality of services, for which the LGAs and the Ministry of Health are responsible for it as institutions and providers (agents).

Among users and dispensary staff the consistent shortage of drugs is frequently cited as a serious challenge. Other challenges included the ineffective institutional setup, skills gaps, lack of support from the top leadership, structural overlap and distance to access services. These challenges posed hindrance to the initiatives that were laid

down by decentralisation for improved public health service delivery. However those challenges are not meant to defeat the purpose of decentralisation and advocate centralization. Policy makers should address these challenges, particularly the drug purchasing and distribution arrangements to reduce the prolonged shortages. Timely supply is critical for medical resources and material and health workers in order to improve quality of services in rural areas. The next chapter summarizes the findings of the study. It also provides the conclusion, recommendations and suggested areas for future research.

CHAPTER SIX

# 6.0 CONCLUSIONS AND RECOMMENDATIONS

## 6.1 Introduction

This chapter provides the overall conclusion of the key findings in relation to the research question. The principal objective of the study was to assess the effectiveness of decentralisation on public health service delivery in rural Tanzania. The study specifically focused on three key specific objectives namely; the institutional characteristics, status of public health service delivery and challenges were thoroughly assessed and analysed.

The chapter provides a snapshot of the study, the summary of major findings, contribution to knowledge on decentralisation and health service delivery, research implications, limitations and recommendations for further studies in the thematic area. The introductory chapter to this thesis provided an introduction and contextualised the premise and importance of this study and its relevance towards knowledge generation with regard to public service reforms and specifically decentralisation under Local Government Reforms and the quest for improved public health service delivery.

A review of theoretical, empirical and conceptual framework was made under chapter two while chapter three dealt with research methodology and methods that were adopted for the study. Chapter Four and five dealt with presentation, interpretation, analysis and discussion of results in relation to the three specific

objectives. This chapter provides conclusions and recommendations based on the findings from both field research and documentary reviews. The chapter also provides the contribution to knowledge in the field of public service reforms and particularly decentralisation and service delivery in the health sector. Finally, the chapter suggests areas for further studies to be undertaken with regard to reforms and service delivery.

## 6.2 Overview of the Study

This study assessed the effectiveness of decentralisation on public health service delivery in rural Tanzania using selected case studies. Pangani District Authority in Tanga Region and Urambo District Authority in Tabora Region were selected as cases for this study.

The study started with an intensive broad review of literature on reforms in public service with a focus on service delivery. The review started at the global level in order to get deeper insights about Local Government Reforms (LGRs), Health sector Reforms (HSRs) and decentralisation as the key cornerstones in the review.

In the review, it was evident that many countries, developed and developing, had attempted and implemented reforms both at central government and local levels. It is imperative to note that the objective of reforms, whether broad or for sector specific centred on improving effectiveness and efficiency in service delivery.

The literature further indicated that, many countries implemented decentralisation as

a policy action and an approach for service delivery. However, the level of implementation, its form and its effectiveness varies from one country to another. The factors for variations are anchored and imbedded on institutional set up within a given country and choice of reforms.

The literature on decentralisation and service delivery indicated mixed results. However, theoretically there is a consensus that decentralisation brings the government closer to the people with assumption that people's needs and expectations would be addressed in an effective and efficient manner. Decentralisation initiatives attracted theoretical and empirical debate regarding its effectiveness inter alia on public health service delivery.

The study adopted qualitative approach to address the main research question. Primary data collected through Interviews, questionnaires, focused group discussions and observation methods. Secondary data was extracted from reports, plans, policies, legislations, guidelines and academic works published and unpublished reports from various sources. This was through a critical analysis of documentary information related to the study. Primary information was qualitatively analysed with the help of Social Science Statistical Package (SPSS) Version 22. The secondary information was also qualitatively analysed through content analysis. The analysis and test of research questions formulated the following major findings as summarized in next section. (Section **6.3).**

## 6.3 Summary of major findings

### 6.3.1 Institutional Characteristics and Their Effect on Public Health Service Delivery in Rural Tanzania

The study established that Tanzania adopted decentralisation reforms and implemented them within a complex and complicated instructional framework. The systems, structures and procedures were not elaborate enough to cultivate a favourable environment for decentralisation to yield the expected outcomes on public health service delivery. The study established further that, the legal framework and the administrative structure of central government show conflicts with the decentralisation policy and theories of decentralisation. The study also established that, the policy, legal and structural framework were the main causes of conflicting roles and responsibilities among those levels and concerned organs hence negatively implicating decentralisation initiatives and health service delivery.

The study tested the knowledge and level of awareness of the respondents in terms of their understanding of the local government policies and laws, systems, structures and practices. It was important to establish whether the respondents had the knowledge on local government policies and laws since these had an impact on access, quantity, quality and the general delivery of public health service delivery in rural Tanzania.

The study established that 92.6% of the respondents on the user side from the selected LGAs were not aware about the decentralisation policies and laws**.** The study also established that the level of awareness impaired the level of accountability

channels on health service delivery to citizens. Lack of awareness affected the quality of service delivery and access by citizens.

The situation was contrary from the service providers, whereas 65% of them were aware on the decentralisation policy and laws. The study established that this level of awareness was a result of workshops and familiarization seminars attended by the respondents by virtue of their position as leaders and employees of the respective LGAs.

The study thought it imperative to know from both demand side and supply side whether decentralisation policies and laws contributed towards improving public health service delivery in rural Tanzania. The study found that 78.8% of respondents from the demand/ user side were sceptical that decentralisation policies and laws did not contribute much towards improving public health service delivery.

The supply (service provider) side, the study found and established that, 75% of health workers agreed that the decentralisation policy significantly contributed towards improvement of public health services in some aspects. On commitment by the central government to decentralise, 60% agreed and 40% disagreed. This indicated that there were issues that needed to be worked upon as 40% of respondents cannot be ignored.

The study also established that 65% of respondents from the supply side agreed that existing policy and laws on decentralisation empower them to execute their plan and budget related to public health. However, 35% were sceptical on the issue of

autonomy. On the issue of relationship between decentralisation and improvement of public health services delivery in local government in rural Tanzania, 60% agreed that there is a relationship however, 40% said there is no relationship.

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### 6.3.2 Status of Health Service Delivery after Decentralisation in Rural Tanzania

The study determined the status of public health service delivery after decentralisation in rural Tanzania. The parameters were in terms of access and availability. The study also aimed to determine the distance, customer satisfaction as measures of quality, availability of essential drugs and medicines. The focus was on the effectiveness of decentralisation reforms on health service delivery in rural areas. The study indicated that 64.6% of the respondents were not satisfied with the availability and access of health centres and dispensaries were located within their Wards or Villages respectively. Whereas 32% of the respondents agreed that health centres and dispensaries were located within their Wards and Villages, hence they are were easily accessible by both men and women.

On the question about reduced distance, the study indicated that 55.8% of the respondents were of the opinion that distance was still a bottleneck to access public health services. On the other hand, 37.9% agreed that there were some improvements. This entails and implies that the effect of decentralisation did not significantly produce the total expected outcomes on reducing distance to locate and access public health services. The achievements were too decimal to be celebrated in this area.

The case of availability of facilities for service provision, the study established that citizens were not satisfied with the facilities and equipments available for health service provision. It was clear that, 22.2% of the respondents strongly disagreed and 46.3% disagreed that Local Authorities health centres had sufficient facilities for health service provision. Only 1% strongly supported and 15.3% agreed that facilities are available for service provision. On the other hand, 15.3% of the respondents were I don't know on this item. This implies that the decentralisation reforms has not significantly achieved the intended objective of ensuring that buildings, office space, beds, delivery kits and other medical equipments were available for improved public health service delivery in rural areas.

The study established that health services to some of the members of the community were imbedded with cost challenges to make them affordable. The findings were clear from the user side indicated as 78.3 of the respondents disagreed indicating dissatisfaction and do not agree that public health services provided by the respective LGAs were affordable. However, 23.2% agreed that services were affordable and they were able to pay. This implies that the reforms minimally influenced positively in this aspect if analyzed in isolation. This means there were still problems with regard to the ability to pay for health services through cost sharing and particularly in rural areas.

On the issue of availability and adequacy of health workers in rural LGAs, the study established that, citizens were not so satisfied with the availability, adequacy and professionalism demonstrated by health workers in the respective cases. About 46.%

% of the respondents disagreed. Some of the respondents indicated some satisfaction as 34% of the respondents agreed that there are some improvements. This implies that the decentralisation reforms had decimal significant affect in this area though there were some achievements noted. Through interviews with the selected key informants, the study established that there were critical shortages of medical staff in all the two LGAs.

The study also established customer-handling mechanisms were not in place to uphold the principle of transparency and accountability. The study indicated that respondents were not aware, whereas 38.9% disagree, 5.9% strongly disagree, and 23.2% were I don't know. The study suggests that even those who were I dont know were likely not informed and that was why they were undecided. A small proportion of respondents that is 29.6% agreed and 2.5% strongly agreed that procedures for accessing services are fair and well known to service users. The study established that citizens were not aware of the procedures, fairness for customer grievance handling in the respective LGAs.

The study established that most of the respondents involved in this study were not satisfied with the availability and sufficiency of essential drugs and medicines in public health facilities located in their areas. About 36.0% of the respondents strongly disagreed on the issue of available and sufficiency of essential drugs to meet the need of the public. While 44.3% disagreed in support of the same position and 12.8% of the respondents were I dont know. Only 6.9% of the total respondents from the user side agreed that essential drugs and medicines are available. The findings

imply that the reforms had not been fruitful in a positive way towards improving health service delivery particularly on the issue of availability of drugs and medicines.

Decentralisation reforms aimed at improving service delivery by ensuring that there is respect of law, human rights and dignity when serving the public. The assumption that public servants observe rule of law, human rights and dignity was valid.

The study established that the reforms significantly contributed towards institutionalization of respect of law, observing dignity and human rights in service delivery in Local Authorities from the selected Councils. The results indicated 64.5% of respondents agreed and 10.3% strongly agreed that health workers observe and adhere to the laws, dignity and human rights.

The study also was able to establish that from both demand side and supply side as well as from other studies indicated that decentralisation has been implemented and there were some improvement to note if analysed in its generality without isolation of items. Findings from the demand or user side indicated that 45.3% agreed that decentralisation has improved health service delivery in rural Tanzania. While 24.6% disagreed and 30% of the respondents indicated that, they Don't know.

This implies that the decentralisation reforms were yet to bear fruits as hoped and expected by the reform agenda. However without going into specific aspects and analysing them in isolation, decentralisation have slightly affected positively the

general health service delivery in rural in Tanzania if compared to the period before decentralisation. The achievements include construction of some dispensaries, increased staffing and accountability as well as upholding human rights and respect of law. However, in its generality the study has established clearly that decentralisation reforms recorded scant and decimal effect with regard to public health service delivery in rural areas.

### 6.4 Conclusions

From the findings of the study, background information, specific objectives, conceptual and theoretical setting and linking decentralisation and health service delivery in local government, this study makes the following conclusions:

The study concludes that Decentralisation as a process and policy action was adopted and implemented with a focus to improve service delivery in Tanzania. The findings and analysis on health service indicated that more still desired for tangible results to be documented and recorded. The initiatives to decentralize health services need to focus on ensuring that the institutional and legal frame is harmonised to foster availability of health services. The health centres and dispensaries in terms of coverage as stated in the health policy should be taken with emphasis. Emphasis also should be on availability of equipments, medical supplies, drugs, reagents, competent human resources for health, technology and other resources to ensure access and quality.

The theoretical implication is that the supply and demand sides as equal partners one is likely to lose trust to the other. The principal agent theory calls for interaction between user and supplier. In the context of this study, the demand side was disadvantaged, as decentralisation had not contributed much towards improving service delivery hence citizen's expectations not realized. This had an implication, which was negative to the demand side caused by the supply side.

The adoption and implementation of decentralisation in local authorities for improved public health service delivery for the past fifteen years in Tanzania has had minimal positive effects. This was because decentralisation process was still farfetched with bottlenecks and challenges. The study results have therefore largely answered the main research objective, which aimed to assess the effectiveness of decentralisation on health service delivery in rural Tanzania. The challenges related to the implementation of the decentralisation were discussed in Chapter five of this study.

The findings of this study justify that, the contribution of decentralisation had minimal and less significant effect on public health service delivery in local authorities in rural Tanzania. The study argues that the policy, legal and structural framework are the main issues that need attention for decentralisation to yield positive effect on health service delivery in rural areas. The level of autonomy was farfetched in the legal framework and administrative structures of LGAs in Tanzania. This affected the flow and availability of resources at the lower tiers of government. On the institutional characteristics, the study concludes that, the nature character and

arrangements of policies, systems and structures negatively affected provision and access to public health services under decentralisation in rural Tanzania. Some of the legal frameworks and guiding principles were in conflict with the thrust to improve public service delivery including health services.

Sensitization programs and awareness building on policies and laws related to decentralisation are critically important for citizen to have a meaningful participation. However, Instituting community involvement in planning process would lead to an increased ownership of such decentralisation reforms, accountability, sustainability, effectiveness and efficiency of the process hence improve health service delivery.

The National Health Policy since 2003 made milestones to have health centres in every ward and dispensary in every village. The decentralisation policy of 1998 clearly aimed to ensure services were brought closer to citizens. However, there was limited and inadequate infrastructure for provision of public health services in terms of facilities in most villages and wards studied. Issues of long distance to access health services persisted in most of the wards and villages. The staffing matter for health workers remained a critical bottleneck hence affecting the quantity and quality of health services provided in rural areas. Despite the coverage issue, less has been achieved in other aspects, such as adequate and availability of essential drugs, medicines and other essential medical supplies.

The general conclusion of this study is that, the Government has undertaken notable

interventions in health by transferring some authorities and responsibilities to the Local Government Authorities through decentralisation. The decentralization reform shows the potential to improve public service delivery in the LGAs. However, decentralisation in local authorities had minimally improved public health service delivery for the past fifteen years in rural Tanzania. The effects noted were too decimal and less to celebrate. Such state of affairs, present both opportunities and challenges on health service in rural areas in terms of availability, affordability, accessibility, responsiveness, participation, and hence improving service delivery. In order to improve the user-provider relations as principals and agents in health service delivery, a number of institutional design and implementation issues should be given a due attention. Policy makers need to address the legal framework to harmonize the existing imbalances in central-local relations by redefining the relationship, functions and roles of central and local governments as institutions.

### 6.5 Contribution to Knowledge

This study employed the institutional and Principal-Agent theories in assessing the effectiveness of decentralization on public health service delivery in rural Tanzania. In so doing, the study has been able to make an empirical analysis on the institutional characteristics, determinants of access and quality of public health service delivery and analysed challenges while guided by those theories hence adding knowledge to the existing theoretical and empirical debate about decentralization effectiveness on public health service delivery in LGAs in Tanzania. The study did shed light on the status of public health service delivery in the respective LGAs with the chosen theories and the conceptual framework. The study has added knowledge through

identification of various challenges ranging from design of reforms, institutional set up, legal framework and their inherent effects on decentralisation outcomes. The study has also been able to suggest possible solutions for the fruition of decentralization and service delivery in LGAs in rural Tanzania. Furthermore, the study discovered broad based challenges on decentralisation and service delivery and captured qualitative contribution on the effect of institutional characteristics on service delivery. The study revealed the effect of awareness on institutional frameworks on the delivery of service and shaded light to policy makers on the type of reforms to be adopted and implemented for improved service delivery (home grown).

### 6.6 Recommendations and Policy Implications

This study zeroed on decentralization and service delivery in the Local Government Authorities in Tanzania and has contributed to the existing literature on decentralization and service delivery. Based on the findings of the study and the overview of implementation process of decentralisation and its effectiveness on health service delivery, the study makes the following recommendations:

- There is a need to enhance public awareness on the Decentralisation policy focusing on key stakeholders including political leaders, council employees and the public. This will improve the expected outcomes.
- There is a need for the government to consider reviewing legal frameworks and institutional set up to address the problem of conflicts on roles and responsibility between central government and local government authorities.

- There is a need for more commitment and political will from both central government and political leadership for successful decentralisation and improved health service delivery.
- Reforms need to be comprehensive to cover both systems, structures, processes and the people that are involved in the adoption and implementation.
- Consideration be made by government to timely allocate resources to facilitate decentralisation reforms hence ensure smooth implementation and fruition on health service delivery.
- There is a need to have integrated reforms, which cut across all sectors due to interdependence nature of public institutions in their operations. The reforms should target political and administrative, economic as well as social cultural arena.
- LGAs may consider ensuring that they effectively involve the communities in setting priorities and planning processes. The available human resources at the LGA levels be well and effectively utilized for fruitful implementation of the plans and projects identified, this will at the end facilitate solving of their socio-economic services and enhance the availability, accessibility and quality of public health services.
- The government may consider reforms agenda to be more home grown with locally developed models to ensure relevance on the model and environment such reforms are implemented. The ownership of reform agenda is very critical for any reforms to bear fruition.

- The initiatives to decentralize on health services need to focus on ensuring availability of health centres and dispensaries in terms of geographical coverage as stated in the health policy.

### 6.7 Areas for Further Research

This study focused on the effectiveness of decentralisation on health service delivery in rural Tanzania. Certainly, it has provoked and give an opportunity for further studies to be undertaken. The studies may include comparing health service delivery in urban settings and rural settings to get more insights as well as to assess the role of leadership and health service management and its delivery in Tanzania.

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# APPENDECIES

## APPENDIX 1:

## INTERVIEW GUIDE FOR LOCAL GOVERNMENT LEADERS

***(Council Chairperson, Council Management Staff, Councillors and Village Chairpersons in selected LGAs)***

1. In your opinion, how do you assess the status of public health service delivery in your area for the past fifteen years in terms of service availability, access and facilities?
2. How do you assess the distance to health services after decentralisation in your area?
3. In your opinion how do you perceive the support from the Central Government for improving public health service delivery in your area for the past fifteen years?
4. In your opinion as a leader, do you think in the past fifteen years citizens are satisfied with public health service delivery in your area?
5. Does community health prioritise in your area appear in the council annual plans and budgets.
6. What are your comments about availability adequacy of drugs, medical equipments and supplies and staffing for the past fifteen years in your area?
7. What challenges have been facing public health service delivery in your area over the past fifteen years.

**THANK YOU FOR YOUR COOPERATION**

**APPENDIX 2:**

**QUESTIONNAIRE FOR MEN AND WOMEN SELECTED FROM RESPECTIVE LGAs/WARDS/VILLAGES**

***(Households and Patients to be found in health facilities)***

By Lufunyo Hussein

The Open University of Tanzania, P.O. Box 23409 Fax: 255-22-2668759Dar es Salaam, Tanzania, E-mail lufunyosh@gmail.com

**Dear Respondent**

You have been selected to participate in a research that is going on in this District which is about **'Effectiveness of Decentralisation on Public Health Service Delivery in Rural Tanzania'.** The main purpose of the research is to assess the extent to which decentralisation has promoted smooth health service delivery in rural areas in Tanzania, All responses provided shall be treated confidentially and the findings shall be used for the purpose of this research and academic purpose only. Therefore, you are kindly requested to participate and respond to all questions openly and truthfully.

**PART A: SOCIO-ECONOMIC INFORMATION**

Name of District..... Name of Ward .....

Name of village..... Date .....

1. Name of Respondent: ---------- (Option)
2. Age (years)

1. 18- 25 2. 25 – 35 3. 35- 45 4. 45 – 55 5. 55- 65

6. 65 and above (Please circle the appropriate number)

3. Sex: 1. Male 2. Female (Please circle the appropriate number)
4. Marital Status (Please circle the appropriate number)
   1. Married
   2. Single
   3. Widow
   4. Widower
   5. Divorced/Separated

5. Occupation (Please circle the appropriate number)

1. Employed
2. Business men/women
3. Farmer/ Live stock keeper
4. Student
5. Fisherman

6. Level of educational (Please circle the appropriate number)
   1. Adult education
   2. Primary Education
   3. Secondary Education
   4. College education with certificate/Diploma
   5. University education with bachelor degree and above

**PART B:**

**INSTITUTIONAL CHARACTERISTICS ON DECENTRALISATION FOR PUBLIC HEALTH SERVICE DELIVERY**

7. (a). Are you aware on any policies and laws used in local government administration in Tanzania? 1. Yes ( ) 2. No ( )

b) . If the answer is Yes in Q. 7(a), Please mention them ----------

---

8(a). In your opinion do you think decentralisation laws and policies have helped to improve public health service delivery in your area? 1. Yes ( ) 2.No( )

(b). If the answer is yes in Q. 8(a), how?

.....

.....

9(a). In your views do you think the mentioned policy and laws (in Q. 7(a)) help citizens to access public health services in your area? 1. Yes ( ) 2. No ( )

b) If the answer is Yes in Q. 9(a), how?----------

c) If the answer is No in Q. 9(b), why? ----------

10 (a). Do you think the existing laws and policies show commitment by the Central Government to decentralize for improved public health service delivery in your area? 1. Yes ( ) 2. No ( ).

b) If Yes why?----------

c) If No. Why?----------

11. In your opinion as a citizen are you satisfied with the institutional set up between central government and local government in view of improving public health service delivery in rural area.

12. To what extent do the decentralisation policy and laws empower the wards and villages to have autonomy over their financial resources for improving public health service delivery

13. How do you pay for public health services? What do you pay for? Who determines the amount to be paid? Do you get involved in determining the payments as a service user?

**PART C:**

**STATUS OF PUBLIC HEALTH SERVICE DELIVERY AFTER DECENTRALISATION IN RURAL TANZANIA( Determinants of PHSD)**

14. Please put a **"√"** below the number in the given boxes that most represents your opinion of agreement or disagreement with the following statement. The table below is a definition of each number as used in this questionnaire;

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **Strongly Disagree (SD)** | **Disagree(D)** | **I don't know(N)** | **Agree(A)** | **Strongly Agree(SA)** |

On the following selected areas, indicate the level of effectiveness of decentralisation in terms of Public health service delivery in rural Tanzania. Kindly provide appropriate response on the following set of questions by putting a tick √ inside the appropriate box of your choice.

| | | | | | |
|---|---|---|---|---|---|
| Public health centre/ dispensary is available, and located within your village and is easily accessed by the public | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public health (centre/dispensary) after decentralisation has sufficient facilities Eg. Buildings, Offices equipments, beds, medical equipments and other supplies) | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public health services are affordable and you manage to pay for such services | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| After decentralisation the distance to get public health services now shorter compared to the previous period | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public servants (health Employees) in your area are sufficient, competent and well trained to do their job professionally. | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public health Services provided by Local authorities in your area are of quality, standard and meet expectations and satisfaction. | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Procedures for customer to access health services are fair and well known to the public. | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public health services are promptly and delivered in time without unnecessary delays. | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public health centre/dispensary has sufficient essential drugs and medicines to suffice citizens needs. | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public health Services are provided responsively without corruption, nepotism and favouritism | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| There is citizens participation and the general public in decision making on key issues affecting public health in your area | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| The public servants (health sector Employees) are accountable to the people (Tax payers) in their functions. | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public health employees in your area are committed, motivated and ready to serve the community. | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Public health employees observe dignity, human rights, respect of law when serving the public. | 1 | 2 | 3 | 4 | 5 |
| | | | | | |

15. List the factors that have contributed towards the realization of your Individual satisfaction with the public health services provided by Local Authorities in your area

1. ….....

2. ….....

16. In your opinion, has decentralisation in Local Authorities had any positive effect on public health service delivery in your area and Tanzania at large? Circle the appropriate answer.

(i) Yes (ii) No (iii) Do not know

If your answer falls between (i – ii) please explain

.....

.....

17. Give comments on what you think could be done to improve public health service delivery by Local Authorities under the ongoing decentralisation in Tanzania

……

**PART D:**

**CHALLENGES AFFECTING IMPLEMENTATION OF DECENTRALISATION FOR IMPROVED PUBLIC HEALTH SERVICE DELIVERY IN RURAL TANZANIA**

18. Mention the challenges or dissatisfaction factors when in need of public health services from health facilities in your area? Mention them if any.

.....

**THANK YOU FOR YOUR COOPERATION**

**APPENDIX 3.**

**QUESTIONNAIRE FOR HEALTH PERSONNEL**

***(Doctors, Nurses and Attendants working in rural Public health facilities in selected LGAs/ Wards/Villages)***

By Lufunyo Hussein

The Open University of Tanzania, P.O. Box 23409 Fax: 255-22-2668759Dar es Salaam, Tanzania, E-mail lufunyosh@gmail.com

---

**Dear Respondent**

You have been selected to participate in a research that is going on in this District which is about **'Effectiveness of Decentralisation on Public Health Service Delivery in Rural Tanzania'.** The main purpose of the research is to assess the extent to which decentralisation has improved health service delivery in rural areas in Tanzania. All responses provided shall be treated confidentially and findings shall be used for the purpose of this research and academic purpose only. Therefore you are kindly requested to participate and respond to all questions openly and truthfully.

**PART A: SOCIO-ECONOMIC INFORMATION**

Name of District.....Name of Ward .....

Name of village..... Date .....

1.Name of Respondent: ---------- (Option)

2. Age (years)

1. 18- 25 2. 25 – 35 3. 35- 45 4. 45 – 55 5. 55-60

(Please circle which is an appropriate number)

3. Sex: 1. Male 2. Female (Please circle the appropriate number)

4. Marital Status (Please circle which is an appropriate number)

   1. Married
   2. Single
   3. Widow
   4. Widower
   5. Divorced/Separated

5. Occupation (Please circle the appropriate number)

1. Medical Doctor
2. Nurse
3. Hospital Attendant
4. Student/internship

6. Highest level of educational (Please circle the appropriate number)

1. Adult education
2. Primary Education
3. Secondary Education
4. College education with certificate/Diploma
5. University education with bachelor degree and above

**PART B:**

**INSTITUTIONAL CHARACTERISTICS AND DECENTRALISATION FOR PUBLIC HEALTH SERVICE DELIVERY.**

7. (a). Do you know any policy and laws used in local government administration in Tanzania? 1. Yes ( ) 2. No ( )

b) . If the answer is Yes in Q. 7(a), Please mention them ----------

---

8(a). In your opinion do you think decentralisation laws and policies have helped to improve public health service delivery in your District council? 1. Yes ( ) 2.No ( )

(b). If the answer is yes in Q. 8(a), explain how?

.....

.....

9 (a). In your views do you think the mentioned policies and laws (in Q. 7(a)) help citizens to access public health services in your health facility? 1. Yes ( ) 2. No ( )

b) If the answer is Yes in Q. 9(a), how?----------

---

c) If the answer is No in Q. 9(a), why?

---

10 (a). Do you think the existing laws and policies show commitment by the Central Government to decentralize for improved public health service delivery in rural areas in Tanzania? 1. Yes ( ) 2. No ( ).

b) If Yes why?----------

c) If No. Why?----------

11. In your opinion as medical staffs are you satisfied with the institutional set up between central government and local government in view of improving public health service delivery in rural areas .

12. Does the existing policy on decentralisation and laws empower you to execute your plans and budget related to public health without interference by the central government? If yes to what extent and in what areas?

13. To what extent doest the decentralisation policy and laws empower the wards and villages to have their health priorities reflected in council plans and budgets for improving public health service delivery?

**PART C: STATUS OF PUBLIC HEALTH SERVICE DELIVERY AFTER DECENTRALISATION IN RURAL TANZANIA**

14 . What have been the major changes brought by decentralisation policy on public health service delivery in your council over the past fifteen years years?

.....

.....

.....

15. (b) If there are any positive changes, what factors have contributed to such changes?

(c). If No, please explain why?----------

---

16. How do people pay for public health services? What do they pay for? Who determines the amount to be paid? are there any incidences where some fail to pay? If they fail what alternative health care do they use?

17. How many medical staff are you in this health facility.....? What is the required number of medical staff which was supposed to be in

place.....?

18. Do you have sufficient medical supplies such as drugs, beds, medical kits, office furniture and equipments to support smooth health service delivery in this health facility?

**PART D:**

**CHALLENGES AFFECTING IMPLEMENTATION OF DECENTRALISATION FOR IMPROVED PUBLIC HEALTH SERVICE DELIVERY IN RURAL TANZANIA**

19. In your opinion can you point out the challenges affecting effective implementation of decentralisation for health service delivery in rural areas.

20. What are the suggestive solutions to those challenges to policy makers and other decision makers?

**THANK YOU FOR YOUR COOPERATION**

**APPENDIX 4: FGDs QUESTIONS FOR MEN AND WOMEN SELECTED FROM RESPECTIVE LGAs/WARDS/VILLAGES.**

1 Do you know any decentralisation policy and laws used in local government administration in Tanzania?

2 In your opinion is distance to health services an issue? If yes or No explain

3 What have been the major improvements in terms of access to public health services (availability, affordability, quality) in your area over the past fifteen years?

4 What do you think have been the contributing factors to such changes?

5 Are community health priorities reflected in District Council plans?

6 How do people pay for health services in this village?

7 Are there any incidences of some citizens failing to pay, what is the magnitude and what alternative health services do they opt to use if any?

8 In your opinion do you think the health facility in your area has adequate medical supplies, essential drugs, beds, office equipments, and buildings to support smooth health service delivery?

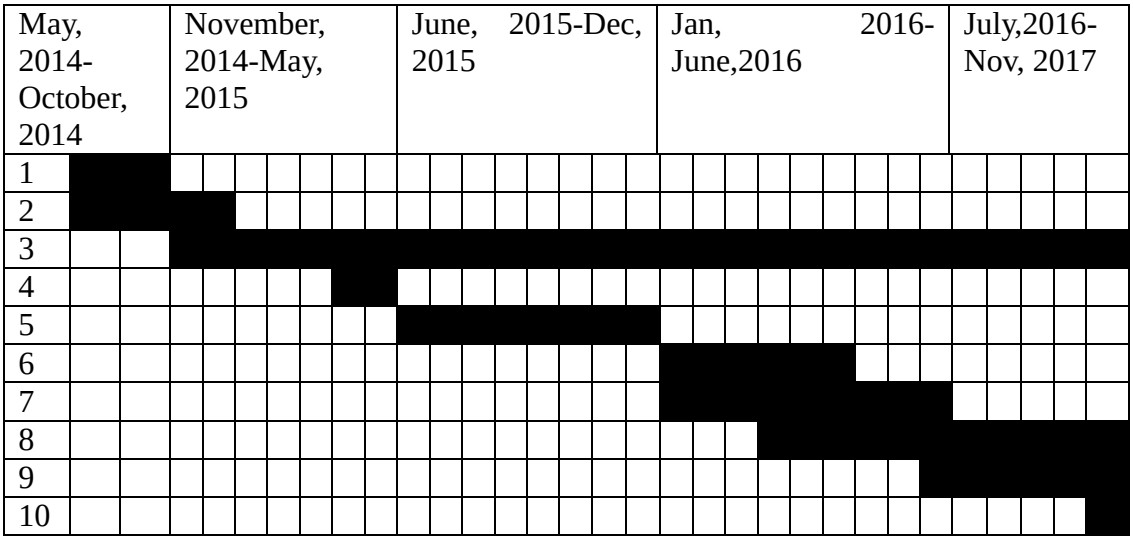
9 Are the medical staff (Doctors, Nurses and Attendants) available and sufficient in number for smooth service delivery in your area?

10 In your opinion, are medical staff (Doctors, Nurses and Attendants) responsive, committed and ready to serve the public in your area?

11 What are the challenges this village is facing in accessing public health services?

12 What do you suggest as a solution to those challenges to policy makers and other decision makes?

## APPENDIX 5. SCHEDULE OF RESEARCH ACTIVITIES




Key

1. Registration
2. Concept note development and presentation to supervisor
3. Proposal writing, literature review, corrections, submission and presentation
4. Proposal corrections after presentation, validation of instruments and submission for approval
5. Data collection
6. Data cleaning, coding, processing and analysis
7. Submission of report for seminar presentation
8. Corrections of report after seminar presentation
9. Thesis writing final draft, binding and submission
10. Invitation for Viva and Graduation for PhD award.

**APPENDIX 6. CLEARANCE LETTER FROM UNIVERSITY TO COLLECT DATA AT PANGANI DISTRICT COUNCIL**

**THE OPEN UNIVERSITY OF TANZANIA**

***DIRECTORATE OF RESEARCH, PUBLICATIONS, AND POSTGRADUATE STUDIES***

P.O. Box 23409
Fax: 255-22-2668759
Dar es
Salaam, Tanzania,
http://www.out.ac.tz

Tel: 255-22-2666752/2668445
ext.2101
Fax: 255-22-2668759,
E-mail: drpc@out.ac.tz
08/05/2015,

DISTRICT EXECUTIVE DIRECTOR

**PANGANI DISTRICT COUNCIL.**

P.O.Box 89,

PANGANI

**RE: RESEARCH CLEARANCE**

The Open University of Tanzania was established by an act of Parliament no. 17 of 1992. The act became operational on the 1st March 1993 by public notes No. 55 in the official Gazette. Act number 7 of 1992 has now been replaced by the Open University of Tanzania charter which is in line the university act of 2005. The charter became operational on 1st January 2007. One of the mission objectives of the university is to generate and apply knowledge through research. For this reason staff and students undertake research activities from time to time.

To facilitate the research function, the vice chancellor of the Open University of Tanzania was empowered to issue a research clearance to both staff and students of the university on behalf of the government of Tanzania and the Tanzania Commission of Science and Technology.

The purpose of this letter is to introduce to you **Mr Lufunyo Hussein; PG201404317**, who is a PhD student at the Open University of Tanzania. By this letter, **Mr Lufunyo Hussein** has been granted clearance to conduct research in the

country. The title of his research is **"The Effectiveness of Decentralisation on Public Health Service Delivery in Rural Tanzania".** The research will be conducted in Sikonge District. The period which this permission has been granted is from 05/08/ 2015 to 05/12/2015.

In case you need any further information, please contact:

The Deputy Vice Chancellor (Academic); The Open University of Tanzania; P.O. Box 23409; Dar es Salaam. Tel: 022-2-2668820

We thank you in advance for your cooperation and facilitation of this research activity. Yours sincerely,

**Prof Hossea Rwegoshora**

**For: VICE CHANCELLOR**
**OPEN UNIVERSITY OF TANZANIA**

**APPENDIX 7. CLEARANCE LETTER FROM UNIVERSITY TO COLLECT DATA AT URAMBO DISTRICT COUNCIL**

**THE OPEN UNIVERSITY OF TANZANIA**

***DIRECTORATE OF RESEARCH, PUBLICATIONS, AND POSTGRADUATE STUDIES***

P.O. Box 23409
Fax: 255-22-2668759
Dar es
Salaam, Tanzania,
http://www.out.ac.tz

Tel: 255-22-2666752/2668445
ext.2101
Fax: 255-22-2668759,
E-mail: drpc@out.ac.tz
,

08/05/2015,

DISTRICT EXECUTIVE DIRECTOR
URAMBO DISTRICT COUNCIL,
P.O.Box 170,
**URAMBO-TABORA**

**RE: RESEARCH CLEARANCE**

The Open University of Tanzania was established by an act of Parliament no. 17 of 1992. The act became operational on the 1st March 1993 by public notes No. 55 in the official Gazette. The Open University of Tanzania charter has now replaced act number 7 of 1992, which is in line the university act of 2005. The charter became operational on 1st January 2007. One of the mission objectives of the university is to generate and apply knowledge through research. For this reason, staff and students undertake research activities from time to time.

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letter, **Mr Lufunyo Hussein** has been granted clearance to conduct research in the country. The title of his research is **"The Effectiveness of Decentralisation on Public Health Service Delivery in Rural Tanzania".** The research will be conducted in Urambo District. The period which this permission has been granted is from 05/08/ 2015 to 05/12/2015

In case you need any further information, please contact:
The Deputy Vice Chancellor (Academic); The Open University of Tanzania; P.O. Box 23409; Dar es Salaam. Tel: 022-2-2668820

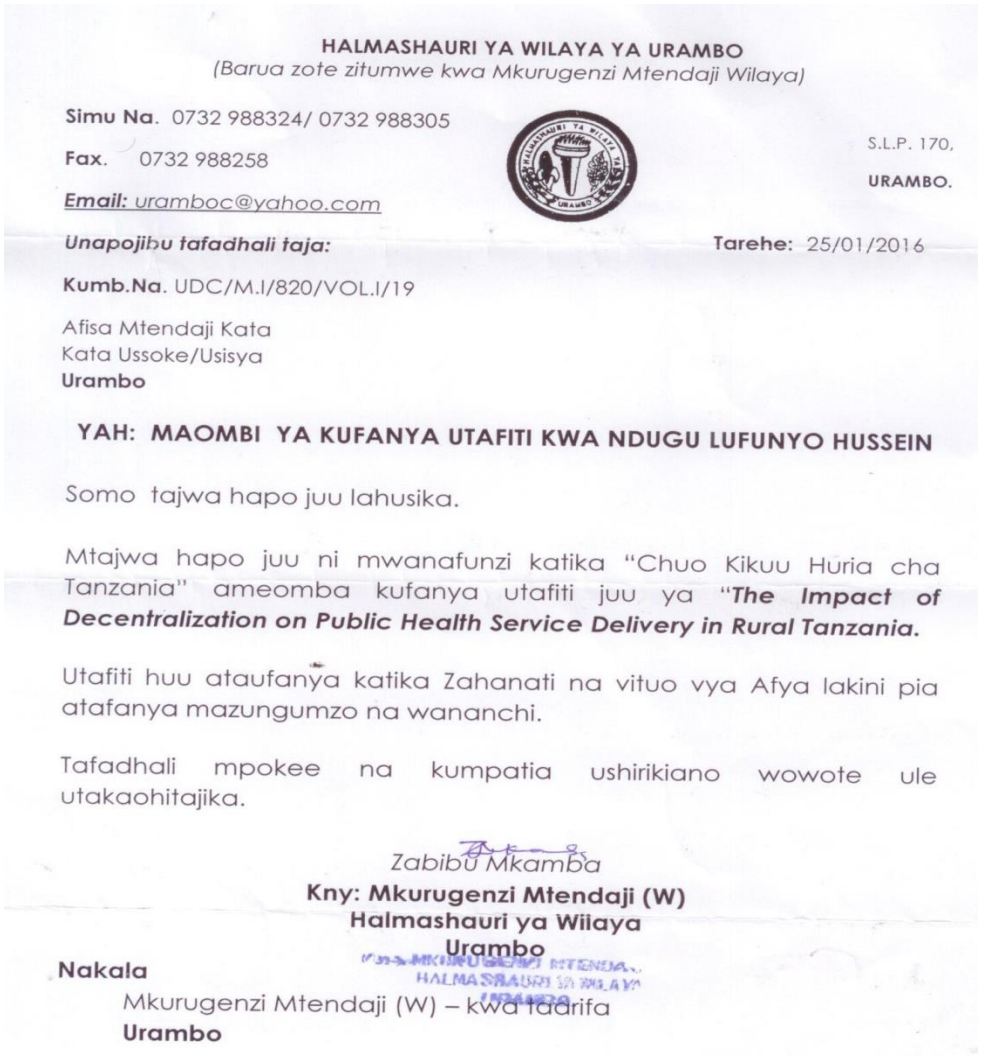
We thank you in advance for your cooperation and facilitation of this research activity. Yours sincerely,

**Prof Hossea Rwegoshora**

**For: VICE CHANCELLOR**

**OPEN UNIVERSITY OF TANZANIA**

## APPENDIX 8 CLEARANCE LETTER FROM URAMBO DISTRICT COUNCIL TO LOWER TIERS OF LGAS FOR DATA COLLECTION



**HALMASHAURI YA WILAYA YA URAMBO**
*(Barua zote zitumwe kwa Mkurugenzi Mtendaji Wilaya)*

**Simu Na**. 0732 988324/ 0732 988305
**Fax**. 0732 988258
***Email:*** *uramboc@yahoo.com*

S.L.P. 170,
**URAMBO.**

***Unapojibu tafadhali taja:***

**Tarehe:** 25/01/2016

**Kumb.Na**. UDC/M.I/820/VOL.I/19

Afisa Mtendaji Kata
Kata Ussoke/Usisya
**Urambo**

**YAH: MAOMBI YA KUFANYA UTAFITI KWA NDUGU LUFUNYO HUSSEIN**

Somo tajwa hapo juu lahusika.

Mtajwa hapo juu ni mwanafunzi katika "Chuo Kikuu Huria cha Tanzania" ameomba kufanya utafiti juu ya "***The Impact of Decentralization on Public Health Service Delivery in Rural Tanzania.***

Utafiti huu ataufanya katika Zahanati na vituo vya Afya lakini pia atafanya mazungumzo na wananchi.

Tafadhali mpokee na kumpatia ushirikiano wowote ule utakaohitajika.

*Zabibu Mkamba*
**Kny: Mkurugenzi Mtendaji (W)**
**Halmashauri ya Wilaya**
**Urambo**

**Nakala**
Mkurugenzi Mtendaji (W) – kwa taarifa
**Urambo**