**International Journal of Social Sciences and Human Research**

Volume 01 Issue 01 December 2018

Page no: 29-52

# The Status of Public Health Service Delivery (PHSD) After Decentralisation in Rural Tanzania

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**Abstract**

This article determined the status of public health service delivery under decentralisation in rural Tanzania. It adopted a combined case study design to explore health service delivery and its status in Pangani and Urambo local government authorities. the study was mainly qualitative; primary data collected by using interviews, questionnaires, FGDs and observation. Secondary data extracted from various reports and academic works related to the theme. The study established that, decentralisation had minimal effect on improving public health service delivery in rural Tanzania. The health services were found to be characterised by poor access and quality. Very few health centres, lack of equipment, drugs and medicines, low levels of competency among health workers, distance, lacked clear complaints handling mechanisms and responsiveness were found to be the major bottlenecks. Delayed service, poor time management, lack of accountability and transparency, lack of political will, poor records management and resistance to change persisted in the sampled health centres. The study recommends a review of the existing legal frame, administrative systems, structures and processes. Efforts on resourcing, Human resource capacity building and institutionalisation of health sector reforms and decentralisation are also recommended.

***Keywords:*** **Decentralisation, health service delivery, rural, local government authorities**

## 1. Introduction

This study set out to determine the status of Public Health Service Delivery (PHSD) in rural Tanzania. The principal focus was to determine the extent to which Decentralisation affected access and quality of public health service delivery in rural Tanzania drawing experiences from Pangani and Urambo Local Authorities.

### 1.2 General overview and background

In the 1990s the World and Africa in particular witnessed changes in managing public service. Many African countries attempted to reform their public sector as a response to political, economic, social and technological changes. The changes encompassed decentralising services to Local Government Authorities (LGAs) with a purpose of improving efficiency, effectiveness and economy in terms of service delivery.

Tanzania was among those countries that took such initiatives to reform the central government and local governments. 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 were implemented on sector specific including the health sector. The reforms at local government were referred to as Local Government Reforms (LGRP).

The LGRs were implemented under Decentralisation approach as a strategy for improving public service delivery to citizens. The two reforms were interlinked and related, this study focused on LGRP, specifically on Decentralisation and health service delivery in rural Tanzania. The decentralisation process in Tanzania dates back to 1960s after independence, however this study focuses on decentralisation

implementation as a result of LGRP of 2000 after passing decentralisation policy in 1998.

In Tanzania the Health Sector Reforms (HSRs) implemented in line with decentralisation. The national health policy of 1995 was reviewed to accommodate decentralisation with a view of improving health service delivery in terms of availability, access, reliability and quality. The 2003 and 2007 National health policies categorically encompass decentralisation as a strategy in managing the health services and its delivery.

However, practical implementation of decentralisation remains a puzzling task with disillusion. For a topic that receives so much attention like this, it is probably a great deal that is still unknown about decentralisation. It is against this background that a study on assessment of effectiveness of decentralisation on Public health service delivery in the LGAs in Tanzania was considered imperative. Specifically the study determined the status of public health service delivery after decentralisation in rural Tanzania.

This study brings to sight the knowledge on decentralisation effectiveness on public health service delivery in rural areas of Tanzania, which is a very important issue to both policy makers and the citizenry. In addition, the study provides useful information on decentralisation and public health service delivery in local authorities hence providing some reflections on policies and laws related to decentralisation and health service delivery.

The study on decentralisation and public health service delivery in rural Tanzania is also informed by the existing debate in academic literature on the contribution and expected results of decentralisation with the inherent quest to improve public health service delivery. The literature and findings from previous studies on decentralisation indicates mixed results on the effectiveness of decentralisation on public service delivery including health services (Kisumbe, *et al..., 2014*). In addition previous studies on implementation of decentralisation indicated a need for research and analysis in the thematic area (Masanyiwa, 2014).

**1.3 Overview on Decentralisation Initiatives.**

The World over three past decades has witnessed a continuous move towards managing public service and modals of service delivery (Njunwa, 2005). Decentralisation and public health service delivery in developed and developing nations has been implemented using approaches of new public management and institutional approach as a guiding framework (Batley, 2004; Larbi, 2005, Masanyiwa, 2013 and Bossert, 2015).

In the contemporary world, reforming Local Governments under Decentralisation approach for public health service delivery has emerged as an important issue 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 services that citizen value. The increased autonomy, particularly by reducing central administrative controls allows sub national governments to design services commensurate to their needs.

The idea of decentralisation is linked to subsidiary principal which connotes that, what can be done efficiently and effectively done at the lowest level of government should be done at that level and not at higher levels (Isaac, 2000 and World Bank, 2004). It further argued that because decisions are being taken in local constituency, citizens have more control over decisions taken and this reflected their preferences.

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).

Globally, governments are striving to deal with the challenge of both economic, democratic governance and public service delivery to the

citizens (World Bank, 2004). Africa as part of the global community cannot be left aside on these initiatives (Herrera and Post, 2014). 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. This initiative has attracted a serious theoretical and practical debate regarding the role and effectiveness of decentralisation on public health service delivery.

Health sector reforms and decentralisation is part of the most critical agenda of many nations intending to strengthen local governments to meet the challenge of 21st Century. Decentralisation has been pursued as one of the solutions to address the challenge of improved public service delivery in rural areas (Herrera and Post, 2014).

In Tanzania the literature indicates that, at independence Tanzania inherited a public service designed to serve colonial interest (URT, 2000). Mushi (2002) and Ringo *et al.*, (2013) observed 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 to dramatic expansion in the role of Government in all spheres; economic, political and social aspects hence in late 1970s and early 1980s the nation faced political, economic and social challenges (URT, 2000 and 2007 and Venugopal and Yilmaz, 2010).

The public service reform initiatives of 1990s in Tanzania, were a response to the deteriorated public services and consequent lost 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 attributed to that anomaly included: expansion of public service structures, pervasive political interference and patronage influence, lowly paid bureaucracy, red tape, 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 of those problematic issues, the government had to rethink and redefine its role, scope of functions, review its structure and redefine the size of the public sector to address the needs and expectations of the society where majority live in rural Tanzania. In order to achieve these objectives the government undertook reforms that included Civil Service Reform Program (CSRP) in 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 hence improve social welfare in the country (URT, 2000).

Mutahaba and Kiragu (2002) pointed out that, the focus of those reforms was to restructure and overhaul the machinery of government, regaining control over the payroll and the size of the establishment, cost containment and retrench surplus staff. The assumption was that the new efforts would cater for improved public service delivery such as education, health, clean and safe water supply, roads and security services and hence improve the welfare of the citizens as key clients of Government institutions (Pallotti, 2008).

Given the limited effectiveness on the quality of public service delivery under the 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 sector reforms (URT, 2000 and 2007).

The Local Government Reforms (LGR) under decentralisation were comprehensive with intent to enhance governance and devolve powers to the grass root governments in order to improve service delivery, participation and accountability (REPOA, 2010). This study however focuses on the effectiveness of Decentralisation on Public Health service delivery in rural Tanzania. The rural Tanzania referred under this study are those established by Act No. 7 of 1982 as amended by Act Number 13 of 2006.

### 1.4 Public Health Service Delivery under Decentralisation in Tanzania

In Tanzania health sector was one of the pioneers of decentralized service delivery through health sector reforms (HSRs). This initiative started early 1990s aiming at improving the access and quality of health services provided to rural communities (URT, 2003 and 2007). According to the National Health Policy, which guided the Health Sector Reforms, district councils are responsible for running district hospitals, health centres and dispensaries in rural areas using subventions from central government and locally generated resources (URT, 2003).

Decentralisation in Tanzania as a service delivery model and process, which involves the transfer of the fiscal, administrative and political authority from the central government to local governments, is viewed as a strategy 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).

Masanyiwa (2013) and UNICEF (2007) noted that, decentralisation in Tanzania has a potential to improve accountability and responsiveness of health services to users at all levels. Decentralisation in Tanzania aimed to improve the access and quality of public healthcare services by strengthening planning and management capacity of local government authorities (LGAs). This was through construction, rehabilitation, extension and provision of equipment to health facilities (URT, 2007).

Decentralisation was meant to transfer administration and management of health services from the Ministry of Health and Social Welfare (MoHSW) to Local Government Authorities (LGAs), health facilities and users (Munishi, 2003; URT, 2003, 2007; Mamdani and Bangser, 2004; Mubyazi et al., 2004; Boon, 2007 and Masanyiwa, 2014). The National Health Policy spells out that health services at district level have been devolved to LGAs 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 of health sector reforms aimed at transferring 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 so doing, the government adopted decentralisation as a strategy, in which LGAs were supposed to be largely autonomous institutions, 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 quality services, including health services (URT, 2005 and Noiset and Rider, 2011). However, since the reintroduction of decentralisation in the health sector in the mid-1990s and 2000, studies indicate that little has been documented on the effectiveness of implementing this policy in relation to health service delivery in rural Tanzania.

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 since 2000 as part of the broad reforms aiming at enhancing the quality, accessibility and equitable delivery of public health services rendered by local government authorities (URT, 2003 and 2007). Tanzania's experience and long history of implementing centralization and decentralisation reforms since independence in 1961 builds a justifiable case for making an assessment and analysing decentralisation and its effectiveness on public health service delivery.

### 2. Statement of the Problem.

Decentralisation and public health service delivery and its status in rural Tanzania remains a topical issue. Since independence in 1961 health issues still remain a priority sector (URT, 2015). The nation state capacity to realize her mandated obligations to the society regarding health care

attracts global and local attention (World Bank, 2004). In Tanzania, the National Health Policy points out clearly that decentralisation of public health service aimed at improving public health service delivery in Tanzania (URT, 2003 and 2007).

The policy further states that decentralisation was aimed to improve health service delivery in terms of accessibility, equity, quantity, quality, affordability and reliability (URT, 2003 and 2007). Similarly the National Health Sector Strategic Plans (HSSP I 1999-2004, HSSP II 2005-2009, and HSSP III 2009-2015) all aimed at ensuring accessibility, availability of medical supplies, human resource for health, reduced distance and effective management (URT, 2007 and 2009). The policy further qualifies that every Ward shall have a Health Centre and villages shall have a Dispensary with consistent supply of essential drugs, medical kits and supplies and staffing of qualified personnel to ensure access is not denied (URT, 2003 and 2007).

The empirical evidence on the ground about decentralisation indicates mixed results on the expected results of decentralisation on public health service delivery. The World Bank (2008) in 20 developing countries including Tanzania, found weaker connections between decentralisation and service delivery in health sector. Mubyazi *et al.,* (2004) also had more or less similar observation regarding the effectiveness of decentralisation on public health service delivery in Tanzania.

Maluka (2011) and Nyamuhanga *et al..,* (2013) focused only on status on the effectiveness of decentralisation and health service delivery. Tibandebage *et al.,* (2013) observed that most of primary health care facilities in rural Tanzania are characterized by inadequately trained staff, experiencing frequent shortages of drugs and supplies and being poorly equipped with necessary medical equipments, however these studies did not cover the reasons for such anomaly. Other studies includes Munishi (2003), Kamuzora and Gilson, (2007), Boon, (2007) Munga *et al.,* (2009), Hussein, (2014) and Sikika (2014). All these studies came up with varied conclusions regarding decentralisation and service delivery.

Despite the broader and vast theoretical supportive and disputed arguments on the outcome of decentralisation in general terms, there is limited evidence on studies that made a comprehensive investigation to determine how decentralisation has been effective on public health services delivery in rural Tanzania. Generally, service users are still discontented with accessibility, quality, and affordability of public health services (URT, 2007; 2009; WHO/UNICEF, 2012 and Twaweza, 2013).

Such state of affairs demand answers on the effectiveness of decentralisation in relation to public health service delivery. To this regard, there is a sound justification and is an issue that calls for an intensive study to be done in this area. This study therefore was sought to determine the status of public health service delivery after decentralisation in rural Tanzania using Pangani and Urambo LGAs.

## 3. Methodology and Methods

The study adopted a combined case study design to determine the status of public health service delivery in Pangani and Urambo local government authorities. the study was mainly qualitative. The primary and secondary data were collected from Pangani and Urambo local authorities. Also secondary data were collected through a critical analysis of documentary information related to this study. Specifically the data were collected through interview, questionnaire, focused group discussions and observation techniques. The data collected were deduced into thematic themes to make them more meaningful and for easy interpretation and analysis. Primary data that relates to the status of health service were coded, entered into computer software SPSS Version 22 and analysed. The computer software assisted and produced frequency tables and percentages for easy interpretation and analysis of respondents' perception on the main theme and questions based on the need (Field, 2009).

## 4. Results

### 4.1 Health service delivery after decentralisation in rural Tanzania

The study tested distance to get health services, customer satisfaction as a measure of quality, procedures to access services, availability of essential drugs and medicines, participation and accountability. In order to determine the status, respondents from both demand and supply side were asked to give opinion in terms of perceived opinion on the quality and access of public health services after decentralisation. 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 considered critically important, as they were the direct beneficiaries of the outcomes and impact of reforms. Table 1 presents descriptive findings on the status of public health services delivery after decentralisati

**Table 1: Responses on the status of public health services delivery after decentralisation**

| Item/Parameter | Strongly disagree (%) | Disagree (%) | Neutral (%) | Agree (%) | Strongly Agree (%) |
|---|---|---|---|---|---|
| Public health centre/ dispensary is located within village | 33(16.3) | 98(48.3) | 7(3.4) | 56(27.6) | 9(4.4) |
| Facilities are availability and sufficiency for service provision | 45(22.2) | 94(46.3) | 31(15.3) | 31(15.3) | 2(1.0) |
| Health Services are affordable and you manage to pay for. | 26(12.8) | 113(55.7) | 24(11.8) | 39(19.2) | 1(0.5) |
| Distance to get public health is now shorter compared to the previous period. | 34(16.7) | 80(39.4) | 12(5.9) | 69(34.0) | 8(3.9) |
| Health workers are sufficient, competent and well trained than before. | 26(12.8) | 68(33.5) | 36(17.7) | 67(33.0) | 6(3.0) |
| Public health Services meets citizen's expectations and satisfaction. | 28(13.8) | 111(54.7) | 29(14.3) | 34(16.7) | 1(0.5) |
| Procedures for customer 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) |
| Health services are promptly and delivered in time | 21(10.3) | 94(46.3) | 20(9.9) | 63(31.0) | 5(2.5) |
| Essential drugs and medicines are available to suffice community's needs. | 73(36.0) | 90(44.3) | 26(12.8) | 14(6.9) | 0 |
| Services are provided responsively without corruption, nepotism and favouritism | 10(4.9) | 55(27.1) | 44(21.7) | 81(39.9) | 13(6.4) |
| There is citizens participation and the general public in decision making on key issues affecting public health. | 23(11.3) | 89(43.8) | 56(27.6) | 35(17.2) | 0 |
| The public servants (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) |
| 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) |
| Public servants observe dignity, human rights, respect of law when serving the public. | 1(0.5) | 13(6.4) | 37(18.2) | 131(64.5) | 21(10.3) |

*Likert scale 1=Strongly Disagree,2=Disagree, 3=Neutral, 4=Agree,5=Strongly Agree*

**Source: Field Survey, 2015**

### 4.2 Availability of Public Health Centres/ Dispensaries

The results indicated that 48.3 % of the respondents were not satisfied with the availability and access of health centres and dispensaries. Those who disagreed were 48.3 % and 16.3% strongly disagreed that health centres and dispensaries are located within their Wards or Villages respectively. About 27.6% of the respondents agreed and 4.4% strongly agreed that health centres and dispensaries are located within their Wards and Villages hence they are easily accessible by both men and women. Also 39.4% of the respondents were of the opinion that distance is still a bottleneck to access public health services. Where 16.4% strongly disagreed and 39.4% disagreed that the distance had not been reduced significantly after decentralisation. Whereas 34.0% agreed and 3.9% strongly agreed that there are some improvements. This implies that, decentralisation of public health services had not significantly impacted positively on availability and access.

This position was substantiated by interviews with key informants from the management teams of respective councils, Councillors and village chairpersons. Documentary analysis also indicated clearly that the number of health centres and dispensaries doesn't match the National Health policy requirements and decentralisation policy as well.

According to an interview with Key informants from Urambo and Pangani districts it was evident that in Urambo there were fifteen (15) Wards but there was only one ward (Usoke) with Health Centre (HC). There were fifty nine (59) villages but only twenty (20) Villages had Dispensaries (D). Pangani District Council had 14 Wards and 33 villages but there was only one (1) Health Centre (HC) at Mwera ward and only sixteen villages (16) had Dispensaries. This defeats the objectives stated in the decentralisation policy and the National Health Policy, which categorically states that every village shall have a Dispensary (D) and every ward shall have a Health Centre (HC) to ensure that services are brought closer to citizens (URT, 2007). The policy further proclaims that the health services shall be available and accessible to all the people in the country (urban and rural areas).

The findings further established that in some areas access is denied due unavailability conditions. This discourages users to access such services as one has to travel to the nearest village or ward to get health services. This also has some financial implication and time to services users contrary to the principles and objectives of decentralisation policy. Table 1 provides a summary of perceptions by respondents.

Interviewees in Pangani District alleged that in some villages citizens had to travel to about 10 Kilometres to get health facilities of which implies that there are added costs if this variable 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 observation of Mamdani and Bangser (2004) is also relevant as public health services in rural Tanzania are often not accessed by the very poor due to key obstacles which include healthcare charges, long distances to facilities, inadequate and unaffordable and unreliable transport systems.

### 4.3 Availability of facilities and equipment for Service Provision

Most of the respondents were not satisfied with the facilities and equipment available for service provision. About 22.2% of respondents strongly disagreed and 46.3% disagreed that Local Authorities health centres have sufficient facilities for service provision. 1% strongly supported and 15.3% agreed that facilities were available for service provision. This implies that the decentralisation had not significantly achieved the intended objective of ensuring that buildings, office space, beds, delivery kits and other medical

equipment were available for improved public health service delivery in rural areas.

The findings were similar to previous studies which observed challenges of inequitable distribution of resources, poor management, underfunding and deteriorating infrastructure leading compromised quality of healthcare and its status in Tanzania (MCSA, 2012). The WHO (2000) similarly asserted that health care in Africa faces difficulties such as shortage of health workers, increased workloads for health workers, poor health facilities and shortage of working equipment.

Sikika (2011) also conducted a study in 71 Districts to ascertain availability of absorbent gauze in health facilities owned by public in rural Tanzania. The findings of the survey indicated that 48% of the health facilities had no absorbent gauze for a period ranging from three to six months. Sikika (2013 and 2014) found that in Tanzania essential medicines, medical supplies, equipments and infrastructure were poorly available in most of the public health facilities, leading to poor service delivery, unnecessary suffering and even deaths of innocent citizens. Ifakara Health Institute (2012) also noted distance, unreliable means of transport, lack of maternity waiting homes, lack of ambulance, lack of consultation rooms, insufficient medical equipment and essential drugs and delivery kits in health centres as a critical bottleneck for improving health service delivery in rural areas in Tanzania.

The key informants pointed out that health buildings, office space, delivery kits, maternity wards and equipment, transport facilities and medical supplies such as gloves and reagents did not suffice the demand. According to the Service Availability and Readiness Assessment (SARA) 2012 survey, 74% of public health facilities had merely half (51%) of the key items that are necessary to provide basic delivery services. JICA (2007) also noted that decentralisation in African was introduced and adopted by many countries but the service delivery including health services was a disappointment.

The World Bank (2010) pointed out that availability and access to infrastructure serves as pre- conditions for quality health services to the population. However, it was further noted that health clinics often lack the basic infrastructure, in particular in public clinics in rural areas posing a challenges to service providers and users. Electricity access, which is limited in several African countries, is important for various equipment usage, and overall use of facilities. Similarly, availability of clean water supply and improved sanitation at the facility level are fundamental for quality services given that un-cleaned water and inadequate elimination of used water are important vector of sickness (ibid).

The interviewees pointed out that sometimes health workers use candle at night to assist delivery for women. Where there is electricity the facility may go for six months without electricity as there is no money to buy electricity units. The study also noted that some health centres' beds had no mattresses and some were too dirty and in bad condition.

### 4.4 **Affordability of services**

The findings in Table 1 established that 12.8% strongly disagreed and 55.7 disagreed indicating that they were not satisfied and do not agree that public health services provided by the respective LGAs are affordable. The study established that services are not affordable and they cannot manage to pay. This means there is still a problem with regard to the ability to pay for health services through cost sharing and particularly in rural areas.

User fees were not the only charges; other costs include transport costs, other unofficial costs including bribes, payments for drugs and supplies. Health care charges all places a financial burden and challenge on the poorest households in rural areas; many fail to access primary health care when they need it most and many more fail to obtain the necessary referral for more skilled care.

Simfukwe (2011) observed that 92.5% of women in Kongwa District Dodoma in Tanzania had information about presence of health facilities

within their District but did not attend in such facilities for maternal because of lack of affordability of transport costs. Maggie (2004), had similar observation that citizens do not always know what they are supposed to pay, legitimate or illegitimate payments. The Official charges are not necessarily affordable, unofficial charges are still in place, and exemption, and waivers have not been effectively implemented especially to pregnant women, children under five years and those of elderly age.

The study established that citizens in rural where the economic situation is crippled, costs for treatment made some of them to sell their produce to meet such costs. This situation integrated 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 noted through the interviewees that, some of the citizens as a solution to run away from those costs from conventional treatments opted for traditional treatment, which significantly affected them.

### 4.5 Availability and adequacy of health Employees in LGAs

General respondent's opinion as indicated in Table 1 shows that, respondents involved in this study were not so satisfied with the availability of health workers and professionalism demonstrated by Local Government employees. About 12.8% strongly disagreed and 33.5 % disagreed that health personnel are available while 33% agreed and 3% strongly agreed that there are some improvements. This implies that the decentralisation reforms have not impacted much in this area though there are some achievements noted.

The study also through interview with the selected key informants established that there was critical shortage of medical staff in all the two councils where the study was conducted. In the interview with the officers responsible for health personnel in the respective councils it was observed that despite the fact that Pangani LGA had only one Health centre, also the staffing issue as per existing establishment had a deficit of Medical Doctors, nurses and other professional for the health centre. The reviewed document indicated that, the requirement for the Health centre was 35 employees but the actual available number was 16 staff only. 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.

Similarly at Urambo District Council the situation was the same. There was only one health centre, the staffing for medical staff was also not sufficient as per establishment. The requirement was 35 staff for the Health Centre but during the study only 11 staff were available. 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 District council. At the District level entirely inclusive of District hospital, Health Centres and Dispensaries the shortage for Urambo District 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 did they real had an Ambulance for emergency and referral cases. Also there was no mortuary attendant, pharmacist, medical doctor, lab technician and medical records management assistant.

This connotes that access, quality, reliability, sufficiency, dependability and availability of health services in those LGAs is questionable and still challenged despite decentralisation policy being in operational. The study through secondary information 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. Among them 69% of medical doctors are in urban areas hence leaving the rural understaffed and consequently impairing

the quality of health services in rural areas (URT, 2012 and 2013).

The study further made reference on Human Resources for Health (HRH) and established that a crisis which has grown into common phenomenon in the health sector was highly associated with maternal deaths. URT (2013) clearly noted that Human Resource for Health crisis is recognized and recorded as one of the major stumbling block towards achievements of Millennium Development Goals (MDGs), particularly those related to maternal and child health (URT, 2013).

Munga *et al.,* (2009) found that that recruitment of health workers under a decentralised arrangement has not only been characterised by complex bureaucratic procedures, but by severe delays and sometimes failure to get the required health workers. The study also revealed that recruitment of highly skilled health workers under decentralised arrangements may be both very difficult and expensive (Hussein, 2015). Fear of the unknown affected smooth implementation of decentralisation for service delivery (Hussein, 2013).

The issue of health workers shortage was further affirmed by the study when respondents were asked whether the services meets quality standards and they are 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 that services meet quality, expectations and satisfaction of users. A few of them 16.7% agreed that services are of quality and they meet expectations and satisfaction of users. In an interview with service providers they pointed out that quality is a challenge hence expectations and satisfaction to service users is below average due to multiple challenges facing health sector in rural areas including 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.

### 4.6 Customer handling procedures, awareness and its implication on health Service

General respondent's opinion as indicated in Figure 4.10 below shows that the respondents who were involved in this study at the time of field visits were not aware whereas 38.9% disagree and 5.9% strongly disagree and 23.2% were neutral. The study suggests that even those who were neutral are likely to be not informed and that is why they were undecided. A small proportion of respondents 29.6% agreed and 2.5% strongly agreed that procedures for accessing services are fair and well known to service users. From the findings the analysis indicates that citizens are not aware with the procedures, fairness for customer grievance handling in the respective LGAs.

The study through interview with the Management of respective councils admitted that they haven't developed yet the charters which articulate procedures for accessing services and outlining duties and responsibilities for both parties (supply and demand side). The study through an interview with departments responsible for Human Resource Management when asked if there are regular seminars and training on customer care and service management for medical staff said they have not organized such training due to budgetary constraints on training budgets.

The study through other studies established that, Citizen Demands 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). Citizens are no longer considered as passive and inactive subjects in the society and cannot be under estimated. Noting this assumption, this study considered the issue of openness on customer grievance procedures as critical in determining the health status in rural areas Tanzania.

The study also found that, the LGAs reforms among other things emphasized institutions to institutionalize Client Service Charters as one among many tools of managing performance and service delivery in Public institutions in Tanzania.

At the time of study, the study established that there was no any means and mechanism available for citizens to report grievances or positive comments on conditions of services offered in those facilities such as suggestion boxes or cellular phone numbers for facility in charge or any leader.

The charter describes all the services the institutions offers, set standards, time for processing such service, duties and responsibilities for both client and institutions. It also sets out feedback mechanisms including a system of handling public complaints. The charter is developed in consultation with its clients, staff and stakeholders that continually grow with an institution (URT, 2012). Above all Client Service Charters (CSCs) are aimed at improving efficiency and effective service delivery in terms of quality, quantity and Economy.

Njunwa (2010) opined on the same position alluding that, serving the citizen better has become a major pre- occupation of Public institutions in both developed and developing countries. Public institutions needs to change the notion of serving the public as abstract and passive subjects hence treating the same as recognizable and respectable actors, capable of influencing policies, processes and making public institutions more responsive to the citizenry needs, demands and concerns.

The study established that there is solid and compelling evidence that clear and well known procedures influences users to access health services, where procedures and communication mechanisms are not well known to clients there is an adverse effect on initial access to health services and its subsequent quality. Such challenges have potential opportunity to affect both the demand and supply side. Patients face significant barriers to health information and disease prevention programs: there is also evidence that they face significant barriers to contact with a variety of health service providers from respective facilities (Chapman, 2009).

The consequence of institutions failing to institutionalize service charters which outline procedures for service delivery and timeframe for services entail services are likely to be delayed hence citizens cannot be timely served hence impairing responsiveness of health services.

The study through interviews with key informants established that delay of service delivery if perpetuated by shortage of staff, facilities, space for service provision and distance for citizens to access services. The opinion from interviewees from the supply side said the situation is moderately fair. The study in assessing timeliness was also interested to test levels of corruption and nepotism in public health service delivery. The respondents from the demand side indicated that in this area there is some improvement whereas 39.9% agreed and 6.4% strongly agreed. The remaining 27.4% disagreed, 4.9% strongly disagreed and 21,7 were neutral. The analysis indicates that though there are some improvements but still elements of corruption, nepotism and favouritism still exist.

REPOA (2008) also arrived in similar conclusions that corruption level are relatively decreasing after decentralisation. However, it should be noted that this keeps on changing depending political will to address corruption despite the existence of responsible institutions. Njunwa (2010) also pointed out that Corruption is still widespread, in spite of the national anti-corruption policies and instruments. 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. Rispel et al., (2015) also noted the negative effect of corruption and other unethical conducts on health service delivery. Similary Brinkerhoff and Bossert (2014) and Cockroft (2014) in Rispel *et al.,* (2015) found that there is a relationship between corruption and health service delivery. They noted that corruption in health service management and delivery affects access and quality, denies the poor the right to health.

### 4.7 Availability and adequacy of essential drugs/ medicines

Table 1 shows that, the respondents who were 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% strongly disagreed on the issue of available and sufficiency of essential drugs to meet the need of the public while 44.3% also disagreed in support of the same position and 12.8% were neutral. 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 have not impacted positively towards improving health service delivery particularly the issue of availability of drugs and medicines.

This position was also supported by the position of respondents from the supply side where the it was established that 90% of the respondents who were the health workers in visited facilities alleged that there is 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.

The article also through interview with key informants who participated in this study established that there is a challenge with the ordering schedules from medical stores department, delay of funds and cumbersome procurement procedures.

The study further made a review and analysis of secondary information to triangulate the information and add on the credibility of primary findings from the field. The study established that the governance of health care in Tanzania has largely been decentralized since 1998 (Macha et al, 2011). The system has been broadly classed into three functional administrative levels - district, regional and national (URT 2009). This implies that there is 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 services, are delivered on time and responsively to citizen needs.

The World Bank (2010) also established and noted that lack of basic medical material and equipment is often an important constraint and challenge to accessibility and quality of health care services. The Controller and Auditor General (CAG) Audit report for Financial Year 2010/11 also established a series of shortcomings 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 8 billion Tanzanian shillings had expired while stored at The Medical Stores Department (MSD)while health centres and dispensaries in rural areas were experiencing acute shortages of essential drugs and other supplies (URT, 2011).

The article established that, challenges in decentralised local government authorities for improved public health service delivery in rural Tanzania are 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 .

The article indicated that most of the challenges created practical bottlenecks which were centred around availability, accessibility, availability of facilities, availability of drugs and other resources. Other challenges included; Reluctance to changes especially mind set to some employees to accept changes. Fear of the unknown affected smooth implementation of decentralisation for service delivery. Poor working and conditions to health workers affected negatively decentralisation and posed a critical challenge on motivation and retention of health workers and the subsequent service to the public. Also inadequate facilities (such as offices and equipment) pose status on the quality of health care provided. Inadequate medical supplies in public health facilities and exemptions for cost sharing in health services.

Lack or in adequacy of essential drugs and medicines, delayed allocation of resources all together were serious challenges which impaired both availability, access and quality of health care and the ultimate outcome of decentralisation policy. Weak legal frame work to address corruption and Poor customer focus culture to some public employees, lack of accountability, distance to access health services, housing for health workers and costs of health services. All these challenges together and collectively affect fruition of decentralisation and its impact on service delivery.

## 5 Conclusions and recommendations

The general conclusion of this study is that decentralisation in local authorities for improved public health service delivery for the past fifteen years in Tanzania had minimal and less positive effects. However the same presents both opportunities and challenges on public health service delivery 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 on health service delivery, a number of institutional design and implementation issues should be looked into and due attention be made. Policy makers need to address the legal frame work to harmonize the existing imbalances in central-local relations by redefining the relationship, functions and roles of central and local governments as institutions.

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