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The Decentralisation Challenges on Public Health Service Delivery in Rural Tanzania

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Abstract
This study assessed decentralisation challenges on health service delivery in rural Tanzania. It adopted a combined case study design to explore health service delivery challenges in Pangani and Urambo local government authorities (LGAs). Both qualitative and quantitative approaches were employed, primary data was collected using interviews, questionnaires, FGDs and observation. The study established that, decentralisation had minimal positive effect towards improving public health service delivery in rural Tanzania. Legal framework systems and administrative structures were the main hindrance in the implementation of decentralisation of health services and its delivery in the rural areas. Health services were found to be characterised by poor access and quality. Unavailability of health centres, equipment, drugs and medicines, health workers, mechanisms for handling complaints and responsiveness were found to be the major challenges. Delayed service, time mismanagement, 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 framework, 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

Introduction

This study investigated the decentralisation challenges on public health service delivery in rural Tanzania, using Pangani District Authority in Tanga Region and Urambo District Authority in Tabora Region as case studies. The study reviewed reforms in public service with a focus on public service delivery. Whereas many countries have implemented the reforms at the central government and local levels, it is imperative to note that the objective of such reforms whether broad or sector specific were all centred on improving effectiveness and efficiency in service delivery (Hope, 2001; Daherty *et al.,* 2002;World Bank, 2005;Hussein, 2013).

Decentralisation has been implemented by many countries; however, the level of implementation, form of decentralisation and its impact all varies from one country to another. The factors for variation are anchored and imbedded in the institutional set-up and choice within a given country (Besley*et al.,* 2003; Larbi, 2005). The design and impetus for decentralisation have indicated to be more influenced by external pressure hence impacting on the expected outcomes (Hussein, 2013, 2014; Masanyiwa*et al.,* 2013).

Theoretically, there is a consensus that decentralisation brings the government closer to the people hence assuming people's needs and expectations will be addressed in an effective and efficient manner. However such initiatives have attracted theoretical and empirical debate regarding their impact on public health service delivery. Health sector reforms and decentralisation were part of the critical agenda of many nations intending to meet the challenges of the 21st Century and Millennium Development Goals (MDGs). Many nations adopted and implemented decentralisation as a solution to address the challenges of public service delivery in rural areas including health services (Akin *et al.,* 2005;Herreta& Post, 2014).

Decentralisation challenges and public health service delivery in rural Tanzania remains a topical issue (World Bank, 2004).In Tanzania, since independence in 1961, health issues have remained a priority sector (URT, 2015). The nation state capacity to realise her mandated obligations to the society regarding health care attracts global and local attention (Boex, 2003;World Bank, 2004). The National Health Policy clearly points out that decentralisation of public health service is aimed at improving public health service delivery. The policy further states that decentralisation is meant to improve health service delivery in terms of accessibility, equity, quantity, quality, affordability and reliability. 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, 2003,2007).

Empirical evidence on decentralisation indicates mixed results on the expected impacts of decentralisation on public health service delivery. REPOA (2008) noted that decentralisation in LGAs and service delivery produced mixed results with notable challenges. The World Bank (2008) in a study of 20 developing countries, including Tanzania, found weaker connections between decentralisation and service delivery in the health sector. Mubyazi *et al*. (2004), Maluka (2010) and Nyamuhanga (2013) noted similar challenges on the impact of decentralisation and health service delivery.Tibandebage *et al.* (2013) observed that most of primary health care facilities in rural Tanzania are characterised by inadequately trained staff, frequent shortages of drugs and supplies, and insufficient necessary medical equipment. 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 public service delivery in Tanzania.

Despite the broader theoretical supportive and disputed arguments on decentralisation and public service delivery in general terms, there is limited evidence on how decentralisation challenges affect public health services in rural Tanzania. To this regard, there is sound justification and it is an issue that calls for intensive research in this area. Also little is written about decentralisation challenges on rural public health service delivery, especially at the sub-district levels in Tanzania. This article seeks to contribute to this debate by assessing empirical data to test the validity of the theoretical debate on decentralisation and public health service delivery in rural Tanzania. This article therefore assesses decentralisation challenges on public health service delivery in rural Tanzania using the selected Rural District Councils.

Literature review

Since 1990s, the World and Africa in particular have witnessed notable changes in managing public service (Hope,2001;Andrews *et al.,* 2007). Many African countries have attempted to reform their public sector as a response to political, economic, social and technological changes (Andrews *et al.,* 2003). The changes encompass decentralising services to Local Government Authorities (LGAs) with the purpose of improving efficiency, effectiveness and economy in terms of service delivery.

Tanzania is one among of the countries which have taken such initiatives, by reforming both the central and local governments. The central government reforms were broad reforms referred to as Civil Service Reforms (CSRP) in 1990s and later Public Service Reforms (PSRP I and II) in 2000s. The implementation of the reforms was sector specific, including the health sector. The overall objective of these reforms is to have a smaller, affordable, well-compensated, efficient, responsive and effectively performing public service, which could foster development and sustained economy through improved service delivery and hence improve social welfare in the country (URT, 2000). Mutahaba and Kiragu (2002) observe that the focus of those reforms has been 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 (Hope, 2001; Pallotti, 2008).

Given limited impact of the quality of public service delivery under the Civil Service Reform, the government launched ambitious reform programmes which included the Public Service Reform Programme (PSRP), Legal Sector Reform Programme (LSRP), Financial Sector Reform Programme (FSRP), Local Government Reform Programme (LGRP), Health Sector Reform Programme (HSRP) and other sector reform programmes (URT, 2000, 2007). The Local Government Reforms (LGRs) under decentralisation were comprehensive with the intent to enhance governance and devolve powers to the grass root governments in order to improve service delivery, participation and accountability (REPOA, 2008). The LGRPs were implemented under decentralisation, as a vehicle for improving public service delivery to citizens. The two reforms were interlinked and related; this article focuses on LGRP, specifically on decentralisation challenges and health service delivery in rural Tanzania.

The World Bank (2004) also noted that decentralisation could reach the local clinics, classrooms and water utilities in ways that create opportunities for strengthening accountability and responsiveness. The principle is that, in a decentralised system, public services including health 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;Bossert, 2015).

Health services encompass all services dealing with diagnosis and treatment of diseases, or the promotion, maintenance and restoration of health. They further refer to personal and non-personal health services (WHO, 2015). Health services are the most visible functions of any health system, both to users and the general public; therefore, health services refers to the way inputs such as money, staff, equipment, infrastructure, and drugs are combined to allow the delivery of health interventions. Improving access, coverage and quality of services depends on these key resources being available, the ways services are organised and managed, and on incentives influencing providers and services users. Kwesigabo*et al.* (2012) and Batley*et al.*(2014) observed that critical shortage of trained health staff is a major challenge facing the health sector, aggravated by low motivation of the few available staff in Tanzania. Other challenges facing the health sector include lack of effective staff supervision, poor transport and communication infrastructure and shortage of drugs and medical equipment. Similarly, Gilson (2016) observed that health centres were perceived to be better than dispensaries, in Tanzania. Gilson further noted that satisfaction is an important element of quality health care, often determining patient willingness to comply with treatment and influencing the effectiveness of health care.Hussein (2015) also observed that LGAs in Tanzania have multifaceted challenges ranging from human resources, financial resources and infrastructure which all together affect their capacity to effectively deliver services that meet quality and citizens expectations.

This study was centred within two theories - Institutional Theory and Principal Agent Theory. It recognises the role of institutions in shaping individual behaviours and actions and their interactional effect, which in turn shape institutions. According to Kimaro and Sahay (2007) institutions are important frameworks for making and examining how interactions between agents and actors take place including what is allowed or prohibited, and under what conditions. The Principal Agent Theory, which is considered critical in revealing the roles of different actors in decision making processes, in mediating access to public services among different users, and in enhancing accountability between citizens and leaders, is also considered to be relevant to this study. Bossert (1998) appreciates the importance of the two theories in analysing decentralisation reforms as they focus on the trade-offs between different actors and the changes that decentralisation may bring with them.

The two theories provides an opportunity to view the central government as an institution and principal with the objective of improving access, quality, responsiveness, affordability and equity of public services; and the local government as an institution and agent charged with responsibilities and resources to implement decentralisation policy to achieve the objectives of improving health service delivery. Bossert, (1998) posits that institutional arrangements, which include policies, laws and national guidelines, are pivotal in ensuring decentralisation works for better service delivery.

At the lower level, the citizens or service users and local politicians are principals with a mandate to make decisions on local service delivery 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 and their interfaces, and how these arrangements affect service decision-making processes, service delivery 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 because its expected outcomes partly depend on institutional arrangements and their power relations (Azfar*et al.,* 2004; Batley, 2004). The general principal is that having the right institutional framework results into optimal allocation and use of resources leading 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 service delivery are critically important factors for inclusion.

The role of institutions in 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 the agenda for Millennium Development Goals (MDGs) was another global issue towards decentralisation for public health service delivery (Rondinnelli, 2006).

The framework also appreciates that institutional arrangements and characteristics have impact on decentralisation and its resultant effect on public health service delivery. The institutions include the legal framework, national guidelines, policies, government structure and operating procedures. In this study, the decentralisation challenges on public health service delivery were measured in terms of availability, accessibility, quality, reliability and affordability of such services by users.

Access was measured in terms of availability of public health facilities in rural settings, distance to the facilities, users' ability to pay, staff availability and competence, availability of drugs, medical equipment and other supplies, responsiveness of service providers and level of autonomy in decision making. Standing (1997) and Scholz and Flessa (2015) consider 'access' as a useful and straight forward concept to operationalise because it emphasises the issues of distance and affordability of health services by users.

The causal relations between decentralisation and improved quality of public health services was actually assessed in terms of users' perceived changes on selected indicators, which include: availability of equipment 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. The study focused on the 'perceived quality' of care from the viewpoint of users and not the 'technical' aspects of care (Gilson *et al.,* 1994; Atkinson &Haran, 2005).

The WHO Alliance for Health Policy and Systems Research defines six building blocks of health care systems as measures and components of the building blocks for health service delivery. 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, it refers to the totality of all physical, technical and organisational components or assets that are prerequisites for the delivery of health care services.

Methodology

The study adopted a case study design to explore health service delivery challenges in Pangani and Urambo local government authorities. It also used both qualitative and quantitative approaches to investigate the decentralisation challenges on public health service delivery in rural Tanzania. The primary and secondary data was collected from Pangani and Urambo local authorities. Secondary data was collected through a critical analysis of documentary information related to this study. Specifically, the data was collected through interviews,

questionnaires, focused group discussions and observation techniques. The data was deduced into thematic themes to make it more meaningful and for easy interpretation and analysis. Primary data was coded, entered into computer software SPSS Version 22 and analysed. The computer software assisted introducing frequency tables and percentages for easy interpretation and analysis of respondents' perceptions on specific objectives and questions.

Results

Health service delivery after decentralisation in rural Tanzania

The study investigated factors like distance to health services, customer satisfaction, procedures to access services, availability of essential drugs and medicines, participation and accountability. In order to identify the challenges, respondents from both demand and supply sides were asked to identify key challenges that affect smooth implementation of decentralisation particularly for the health sector. The health workers were considered key players in the drive and implementation of the decentralisation reforms in public service specifically the health sector in Tanzania. The user side was considered critically important, as it was the direct beneficiary of the outcomes and impact of reforms. Table 1presents descriptive findings on the status of public health services delivery after decentralisation.

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

Item/Parameter	Strongly disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
Availability of a public health centre/ dispensary within the village and accessed by the public (men and women)	33(16.3)	98(48.3)	7(3.4)	56(27.6)	9(4.4)
Availability and sufficiency of facilities for public health service provision	45(22.2)	94(46.3)	31(15.3)	31(15.3)	2(1.0)
Affordability of public health services and ability to pay for such services	26(12.8)	113(55.7)	24(11.8)	39(19.2)	1(0.5)
Distance to public health services in your village is now shorter compared to the previous period	34(16.7)	80(39.4)	12(5.9)	69(34.0)	8(3.9)
Healthworkers in your area are sufficient, competent and well trained to do their job professionally than before	26(12.8)	68(33.5)	36(17.7)	67(33.0)	6(3.0)
Public health services provided by local authorities in your area meet citizens' expectations.	28(13.8)	111(54.7)	29(14.3)	34(16.7)	1(0.5)
Procedures for customers 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 in your area are 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 for community needs.	73(36.0)	90(44.3)	26(12.8)	14(6.9)	0
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 citizen participation and the general public 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
Public servants (health sector employees) in your area are accountable to the people (tax payers) in their functions	9(4.4)	61(30.0)	50(24.6)	78(38.4)	5(2.5)
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)
Public servants (health employees in your area) observe dignity, human rights, and 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

Availability of public health centre/ dispensaries and accessibility

The findings indicated that 48.3% of the respondents were not satisfied with the availability and access of health centres and dispensaries. Those who confirmed that health centres and dispensaries were located within their wards or villages were 48.3% while those who strongly disagreed were16.3%. About 27.6% of the respondents agreed and 4.4% strongly agreed that health centres and dispensaries we relocated within their wards and villages hence they were easily accessible by both men and women. Also 39.4% of the respondents were of the opinion that distance was still a bottleneck to access public health services. About16.4% strongly disagreed and 39.4% disagreed that distance had not been reduced significantly after decentralisation, whereas 34.0% agreed and 3.9% strongly agreed that there was some improvement. This implies that decentralisation of public health services had not significantly and positively impacted on availability and access. This position was substantiated by interviews with key informants from management teams of respective councils, councillors and village chairpersons. Documentary analysis also indicated clearly that the number of health centres and dispensaries did not match either the National Health Policy requirements or decentralisation policy.

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 a health centre. There were fifty-nine (59) villages but only twenty (20) had dispensaries. Pangani District Council had 14 yards and 33 villages but there was only one (1) health centre 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 state that every village shall have a dispensary and every ward shall have a health centre, to ensure that services are brought closer to citizens (URT,2007).The policy further proclaims that health services shall be available and accessible to all the people in the country (urban and rural areas).

The findings established that in some areas access was denied. This discouraged users to access such services as one had to travel to the nearest village or ward to get health services. This also had some financial implications and time spent to travel to get services, contrary to the principles and objectives of the Decentralisation Policy. Table 1 above provides a summary of perceptions by respondents.

Interviewees in Pangani District alleged that in some villages citizens had to travel about 10 kilometres to health facilities; this implied that there were added costs, if this variable is to be analysed with other items especially the issue of availability of health centres or dispensaries within villages. 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 high charges, long distances to facilities, unaffordable and unreliable transport systems.

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 the respondents strongly disagreed and 46.3% disagreed that health centres under local authorities had sufficient facilities for service provision. Only 1% strongly supported and 15.3% agreed that facilities were available for service provision. This implies that 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 findings in previous studies which had identified challenges of inequitable distribution of resources, poor management, under-funding and deteriorating infrastructure, all compromising quality of healthcare in Tanzania (MCSA, 2012). WHO (2000) and Bossert (1998) similarly asserted that health care in Africa faces difficult challenges 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 public health facilities, 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, 2014) found that in Tanzania essential medicines, medical supplies, equipment and infrastructure were unavailable 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 buildings, office space, delivery kits, maternity wards and equipment, transport facilities and medical supplies such as gloves and reagents did not match the demand. According to the Service Availability and Readiness Assessment (SARA) survey(2012),74% of public health facilities had merely half (51%) of the key items necessary to provide basic delivery services. JICA (2007) and World Bank(2008) also noted that decentralisation in Africa had been introduced and adopted by many countries but service delivery, including health services, was a disappointment. The World Bank (2010) noted 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 basic infrastructure, in particular in public clinics in rural areas posing a challenge to service providers and users. Electricity, which is limited in several African countries, is important for powering equipment, and for lighting. Similarly, a clean water supply and improved sanitation at the facilities are fundamental for quality services, given that contaminated water and inadequate elimination of wastewater are important causes of sickness.

The intervieweespointed out that sometimes health workers use candle light at night while assisting women delivering babies. 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.

Affordability of services and capacity to pay

The findings in Table 1showthat 12.8% of the respondents strongly disagreed that public health services provided by the respective LGAs were affordable, while 55.7% reported that such facilities were not affordable. . The study established that services were not affordable and people could not pay. This means there is still a challenge 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 included transport costs, other unofficial costs including bribes, payments for drugs and supplies. Health care charges place 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 Region, had information about health facilities within their District but did not use such facilities for maternal issues because they could not afford treatment and transport costs. Maggie (2004) citizens did not always know what they were supposed to pay, legitimate or illegitimate. Again, exemption and waivers have not been effectively implemented especially to pregnant women, children under five years old, and the elderly.

The study established that citizens in rural areas where the economic situation is crippled, costs for treatment forced 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 already critically ill, and died. The study also noted through the interviewees that those who did not afford conventional treatment opted for traditional treatment, which significantly affected their health.

Availability and sufficiency of health employees in LGAs in Tanzania

As indicated in Table 1,respondents involved in this study were not satisfied with the availability of health workers and the professionalism demonstrated by local government employees. About 12.8% strongly disagreed and 33.5 % disagreed that health personnel were available, while 33% agreed and 3% strongly agreed that there was some improvement. This implies that the decentralisation reforms have not had a lot of impact in this area although there was some achievement noted. The study also established that there was a critical shortage of medical staff in all the two councils where the study was conducted. During 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, the staffing establishment had a deficit of medical doctors, nurses and other professionals. The reviewed document indicated that the requirements for the health centre were 35 employees but the actual available number was 16 staff only. In the dispensaries visited, they had only two or three staff instead of five as required by the Council and National Health Policy.

Similarly, at Urambo District Council, the situation was the same. There was only one health centre, and the medical staff were very few. The requirement was 35 staff for the health centre but during the study only 11 staff were on station. The analysis about human resource for health for Urambo indicated that there was a shortage of 44 health employees for dispensaries and health centres for the whole District Council. At the District level (inclusive of the District Hospital, Health Centres and Dispensaries) the shortage for Urambo District stood at 226 medical staff against the required number of 463 medical staff. The whole district had only 237 medical staff available during the study period. At Usoke Health Centre in Urambo, there was no driver for the ambulance, no mortuary attendant, pharmacist, medical doctor, lab technician or medical records management assistant. This goes to prove that in Usoke Health Centre, access, quality, reliability, sufficiency, dependability and availability of health services in the LGAs were still challenges despite the decentralisation policy being in operation. 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 country. The number of health workers was 64,500, expected to serve a population of over 40 million Tanzanians. About 69% of the medical doctors are in urban areas, leaving the rural areas understaffed and consequently impairing the quality of health services (URT, 2012,2013).

The study further made reference on Human Resources for Health (HRH) and established that the crisis which had grown into common phenomenon in the health sector was highly associated with maternal

deaths. URT (2013) clearly noted that the Human Resource for Health crisis is recognised and recorded as one of the major stumbling blocks towards achievement of the 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 had 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 was both very difficult and expensive. Again fear of the unknown affected smooth implementation of decentralisation for service delivery (Hussein, 2013).

The issue of shortage of health worker was further affirmed by the study when respondents were asked whether the services met quality standards and whether they were satisfied with services offered by public health facilities in their respective areas. While 54.7% of the respondents said that they were not satisfied with the standard of quality, 13.8% strongly disagreed that services met quality standards, expectations and satisfaction of users. A few of them (16.7%)said that services whereof the expected quality and they met expectations and satisfaction of users. In an interview with service providers, they pointed out that expectations and satisfaction to service users was below average due to multiple challenges facing the health sector in rural areas including inadequate facilities, shortage of health workers, low morale of employees, delayed supply of essential drugs and medical supplies, poor working conditions and service delivery.

Customer handling procedures, awareness and its implication on health service delivery

Regarding respondents' awareness of procedures for handling grievances, the findings indicated that 38.9% disagreed,5.9% strongly disagreed, and 23.2% were unsure of the fact that people knew the procedures for handling grievances. The study suggests that even those who were unsure were likely to be un-informed, that is why they were undecided. A small proportion of respondents 29.6% agreed that the procedures were fair, while 2.5% strongly agreed that such procedures for accessing services wirehair and known to service users. From the findings, the indication was that citizens were not aware of the availability and fairness of procedures for handling grievances in the respective LGAs.

Management of respective councils admitted that they hadn't yet either developed the charters which articulated procedures for accessing services and outlining duties or outlined the responsibilities for both parties (supply and demand sides). The study through an interview with departments responsible forAsked whether there had been any regular seminars and training on customer care and service management for medical staff training, the Human Resource Management admitted thatthey had not organised any such trainings due to budgetary constraints.

Other studies have established that citizen demands on quality, quantity, economy openness on procedures, rights and duties and timely service delivery from public institutions have become the norm (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 in Tanzania.

The study also found that the LGAs reforms, among other things, encouraged institutions to institutionalise Client Service Charters as one among many tools of managing performance and service delivery in public institutions in Tanzania. At the time of study, it was established that there was no means and mechanism available for citizens to report grievances or give positive comments on the quality of services offered in those facilities such as suggestion boxes or cellular phone numbers.

The charter describes all the services the institutions offers, sets standards, time for processing such services, 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) was of the same opinion alluding that serving the citizens better has become a major pre-occupation of public institutions in both developed and developing countries. Public institutions need to change the notion of serving the public as abstract and passive subjects and instead treat the same as recognisable 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 influence 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 their 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 programmes; there is also evidence that they face significant barriers to make 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 was perpetuated by shortage of staff, facilities, space for service provision and distance for citizens to access services. In assessing timeliness of service delivery, the study 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 was some improvement. The analysis indicated that though there were some improvement, there were still some elements of corruption, nepotism and favouritism.

REPOA (2008) also arrived at similar conclusion that corruption levels were relatively decreasing after decentralisation. However, it should be noted that this keeps on changing depending on the political will to address corruption despite the existence of responsible institutions. Njunwa (2010) also pointed out that corruption was widespread, despite the national anti-corruption policies and instruments. Transparency International (2014,2015) using a Corruption Index, showed that Tanzania was ranked at 119 for 2014 and 117 for 2015, with a score of 31/100 for 2014 and 30-39 for 2015. Rispel *et al*. (2015) also noted the negative effects of corruption and other unethical conduct on health service delivery. Similarly, Brinkerhoff and Bossert (2015) and Cockroft (2014) in Rispel *et al.* (2015) found that there was a relationship between corruption and health service delivery. They noted that corruption in health service management and delivery affected access and quality, and denied the poor the right to health.

Availability and sufficiency of essential drugs/medicines

Table 1 shows thatthe 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 80% of the respondents attested that essential drugs and medicines were insufficient, while only 20% thought availability of such drugs and medicines was satisfactory. 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 respondents from the supply side where it was established that 90% of the respondents who were health workers in visited facilities alleged that there was critical shortage of essential drugs and medicines as well as other medical supplies such as delivery kits for pregnant women, gauze, gloves, reagents and other laboratory material.

This study also established that there was 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 decentralised 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 the 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 a serious 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 aseries 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).

Conclusions and recommendations

Decentralisation in local authorities for improved public health service delivery for the past fifteen years in Tanzania has 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 of health service delivery, a number of institutional design and implementation issues should be looked into and given due attention. Policy makers need to address the legal framework to harmonise the existing imbalances in central-local relations by re-defining the relationship, functions and roles of central and local governments as institutions.

Also a detailed study with a wider scope with regard to public health service delivery in the country is highly recommended. This will probably come out with detailed suggestions on how to improve health service delivery and address the inherent challenges from both user and provider perspectives.

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