THE IMPACT OF ADMINISTRATIVE ATTITUDES ON COMMUNITY PARTICIPATION IN THE DELIVERY OF DECENTRALIZED HEALTH SERVICES IN TANZANIA: A CASE STUDY OF BABATI TOWN COUNCIL

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MASTER IN PUBLIC ADMINISTRATION

THE UNIVERSITY OF DODOMA

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BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN PUBLIC ADMINISTRATION

THE UNIVERSITY OF DODOMA

OCTOBER, 2018

DECLARATION

AND

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by The University of Dodoma dissertation entitled ***"The Impact of Administrative Attitudes on community Participation in the delivery of Decentralized Health Services in Tanzania: A case study of Babati Town Council"*** in partial fulfillment of the requirements for the degree of Master of Public Administration of The University of Dodoma.

Sgnature:..……………..…………………Date:…………………………..

Prof. Amukowa Anangwe

(SUPERVISOR)

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DEDICATION

I dedicate this work to my family and all those who supported me in the completion of this project. Thank you and May God bless you abundantly.

ABSTRACT

The overall purpose of this study is to examine the impact of administrative attitudes on community participation in the delivery of decentralized health services in Tanzania. To achieve this, specific objectives include to identify the impact of administrative beliefs on the community's provision of labour and materials in the health facilities in Tanzania; to examine the effect of administrative perceptions on the community's identified health needs and preferences for human resources, adequate drugs and funds in Tanzania;

To analyze the influence of administrative behavior on the community's selection of technology and the location of medical equipments in Tanzania; and to evaluate the role of administrative feelings in the community's contribution of capital and operations for physical factors in Tanzania. The major theories for guiding this study included social exchange, social capital and principal agency theories.

A case study research design was employed where both quantitative and qualitative approaches were employed. The sample size was 65 respondents comprising 60 health customer respondents who were randomly selected in the field using questionnaires, and 5 key informants chosen by using interview guide. The collected data were analyzed using Statistical Package for Social Sciences (SPSS) computer software program to obtain frequency and percentage.

The findings of the study revealed that administrators had negative attitude towards community participation in the delivery of decentralized health services. This resulted to a weak delivery of health services to the people. The study recommends the increase their participation levels in implementation of primary health care; and both Government and administrative leaders at all levels (village-national) should jointly facilitate community members to solve major constraints.

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ABBREVIATIONS AND ACRONYMS

CCHPs	Comprehensive Council Health Plans
CG	Central Government
CHF	Community Health Fund
D by D	Decentralization by Devolution policy
DC	District Council
EAC	East African Community
GIZ	German Agency for International cooperation
HFS	Health Financing Strategy
HR	Human Resource
LGAs	Local Government Authorities
MC	Municipal Council
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
NGOs	Non Government Organizations
NHIF	National Health Insurance Fund
PHC	Primary Health Care
SCM	Supply Chain Management
SPSS	Statistical Package for Social Sciences
TSPA	Tanzania Service Provision Assessment Survey
UN	United Nations
URT	United Republic of Tanzania
USAID	United States Agency for International Development
W.H.O	World Health Organization

CHAPTER ONE

1.1 Introduction

The main purpose of this chapter gives the setting positions of the study. The study is concerning the impact of administrative attitudes on community participation in the delivery of decentralized health services in Tanzania. This part contains several sections which include the background to the study, statement of the problem, research purpose and objectives, research questions as well as significance of the study.

1.2 Background to the Study

This section has the purpose and should set out for stating the context in which the research took place, the reasons why this study was carried out and the way the dissertation is to be organized.

Decentralized health services delivery in Tanzania is said to have gone hand in hand with the decentralization of other social services in which LGAs were given mandate to provide such social services to people, leaving Central Government as an overseer for the service provided (Mzenzi, 2015). This happened in 1980s when it became clear that centralization process failed to provide service to people. It ought to be recalled that 1980s was a decade of serious economic crisis which meant that the government could no longer keep to its promise of providing services to the citizen. During this decade, the economic performance of Tanzania was worsened mainly by the oil shock, collapse of the East African Community (EAC), the impact of the Uganda-Tanzania war, and persistent drought (Lunogelo, 2010; Bigsten, 1999). As a result, economic and governance reforms were to be introduced to try

and bring the economy back to stability. This was the context in which in 1982, the government introduced Local Government Authorities (LGAs).

Decentralization in Tanzania is highly associated with local government authorities and has been practised in the country in varying devolution since colonial times (URT, 2005). Historically, the concept of decentralization has never been a new policy in countries across the globe. However, the term attracted attention in the 1950s and 1960s when British and French colonial administrations prepared colonies for independence by devolving responsibilities for certain programs to local authorities (Ndunguru, 2008; Nelson, 2000).

Soon after independence, that is, from 1961 - 1980, Tanzania like many other developing countries, set out ambitious social and human resources development plans, including programmes generally aimed at the eradication of poverty, ignorance and diseases in a matter of two decades (URT, 2000; 1996). It was during the period that Tanzania in 1972 adopted numerous top down policies including, Socialism and self reliance in 1967 and the decentralization policy of 1972, which focused on decentralizing key authorities and functions of government from the centre to the grassroots level, so as to enable the community to participate in decision making (URT, 2004; 2003; 2000). For instance, from 1960s to 1980s the CG played a key role in providing health care in which modest success was recorded. However, as time went on the CG faced numerous problems that led into the need to decentralize health service delivery in which LGAs became key providers of health service. Indeed, the decentralization of health service that is practised through Health Sector Reform (HSR) gained much appreciation from scholars (Mujinja and Kida, 2014; Chotara and Tumusiime, 2004). It is said, for

instance, that under decentralization of health service people could enjoy greater equity and quality of health, obtain greater value for money through cost effectiveness and improve functioning and performance of health systems (Cassel and Janovsky, 1996; Mujinja and Kida, 2014).

In the 1980s, several countries like Armenia, Bosnia-Herzegovina, Brazil, China, El Salvador, Georgia, India, Mexico, South Africa, Uganda and Uzbekistan adopted policies on the decentralization of the delivery of health services (Conning and Kevane, 1999; Bardhan and Mookherjee, 2005; Bashaasha et al., 2011). People at the local level kept a check on the delivery of health services than a distant central authority. Health organizations had also stressed the importance of community participation in the delivery of health services (WHO 2006). The main aim of involving communities in delivery of health services and management was to make sure that the voices of the poor are heard. Similarly, scholars like Ruiters and Niekerk (2012) also stressed that, the right to a healthy life and healthy environment are entitlements of citizenships.

Nigeria formulated a National Health Policy, with an emphasis on primary health care delivery. The critical thrust of the policy was to help Nigerians lead socially and economically productive lives. Investment in health care was expected to bring about improvement in such key indicators as widespread access to service facilities, improved facility use rates, and a reduction of household expenditure (Okojie, 2009, P.16).

In Babati Town Council in the Manyara Region where this study was conducted, studies by Borneskong (2010) show that, after an introduction of administrative

decentralization in the country the different local levels of government were about to be responsible for the local population in order to make it easier to cover all of their needs for health services. But currently, this is not working in practice. For instance, Babati (Mrara) Town Hospital in Babati was serving a larger population before the introduction of decentralization than they are now. In reality, the hospital is still taking care of some of those people who do not lie within their responsibility anymore. The additional number of patients that are being taken care of, however, is not included in their budget. In addition, there are many different ethnic and religious groups with different needs and opinions in Babati; this has resulted in some disparities on how to manage the decentralized health services. Therefore, this study intended to assess impact of administrative attitudes on community participation in the delivery of decentralized health services in Tanzania: A case of Babati Town Council.

Community participation is the heart and pre-requisite pillar of the delivery of decentralized health services approach (Tatar, 1992). The delivery of decentralized health services was discussed in the world health conference known as Alma Ata-Declaration in 1978 which embodied terms such as self-reliance and self-determination (WHO, 2006). Community participation involves taking part in the development process affecting communities; such as expressing demand for health needs, being involved in the selection of technology and the location, providing labour and the materials, contributing to capital and operation as well as maintenance costs.

In Tanzania, community participation in the delivery of decentralized health services was revived since attainment of independence in 1961. Tanzania changed a model of

delivering health services from Central Government (CG) to Local government Authorities (LGAs) (Challigha, 2008). It was presumed that, inactive community participation in the delivery of decentralized health services can result to weak delivery of health services to the people.

Kihehere, (2013) conducted a study on citizen participation and health service delivery in Uganda. The overall findings of this study also examined that, as a result of the government's decision to abolish payment of user fees in public health facilities. Findings further indicate that the poor patients were no longer limited by finances to access the health facilities as it was the case before the government stopped off the user fee policy. However, the responses from the participants in this study also demonstrate that the free access to the facility does not guarantee the availability of quality services at the facilities.

Surveyed respondents in Kinondoni MC and Ulanga DC by Marijani, (2017) on Community Participation in the Decentralized Health and Water Services Delivery in Tanzania reported that they were participating in the health policies implementation through attending public meetings, receiving feedback on services, promotion services, attending presentation about health behaviors, as well as family visits; the findings further discovered that community members were concerned in assessment of their health needs. To a small extent 9.8 percent of the respondents reported to participate in Kinondoni and 14.8 percent of the respondents reported to participate in the assessments of their needs in Ulanga DC. Community participation at this level is realistic and active specific. The above findings are in sharp contrast with (Maluka, 2011) conclusion that decentralization in whatever form does not automatically provide space for community; the assumption that devolution to local

governments promotes transparency, accountability and community participation is distant from reality.

Tanzania has developed governance structures for participation in the health services (Kessy, 2014). For example, users are involved in the implementation of the policies through planning and management of the health services delivery (COWI/EPOS, 2007). Yet, the composition of the board/committee, the responses was still skewed in favour of health staff. In Kinondoni 95.0 percent of the respondents mentioned the health staffs as committee and boards members, whereas 76.9 percent of the respondents reported the same in Ulanga DC. Besides, study respondents indicated that there was minimal community participation in the health boards and committees as reported by 5.0 percent of all respondents in Kinondoni MC and not a bit of the respondents in Ulanga DC.

Finally, a study in Kenya of volunteers who took part in a community-based health development programme addressed the issue of community leadership and participation (Kaseje, et al., 1987). Because growth monitoring has been recommended as an entry point to PHC (Genece& Rohde, 1988), community development has been considered to be a starting point for community participation in health programmes (Charles & Charles, 1987). Efforts to encourage community participation in health sector are being carried out in the Arab countries of the WHO Eastern Mediterranean Region. Saudi Arabia has adopted the strategy of Health for All by the Year 2000 as well as the resolution taken in 1978 adopting the Declaration of Alma-Ata (WHO, 1978&1981). Supported by a five-year plan, the Saudi Ministry of Health embarked in 1985 on nationwide implementation of PHC, including community participation.

In the Alma Ata Declaration community participation contains involvement in all phases of primary health care. In the Primary Health Care Approach, community participation is one goal of health care reform and also a means to reach the other objectives like equity. The expected outcomes of community participation in the health sector include more health consciousness and knowledge, further pushing up the demand, more access to health care through community-level workers, and improvements of community level health infrastructure (Chatterjee, 1988). The major theoretical framework for community participation has been done by the Cornell University (Uphoff et al., 1979). The Cornell study is based on questions about the kind of participation, who participates and how participation occurs. Participation may take place in decision-making, in implementation, in benefits, and in evaluation. The participating individuals or groups may be local residents, local leaders, government personnel, and foreign personnel.

Administrative attitudes in the organizational delivery of the decentralized health services, hospital networks, and other health care settings can greatly affect health outcomes, quality of care, and patient satisfaction. Meier's works showed that administrative attitudes may affect health programme (policy) implementation (Meier, 1993; Meier and Nigro, 1976) and administration at the ground level (Kropf et al., 2012). The crucial role of implementation agencies and their employees in shaping the actual policy outcome was acknowledged strongly by Lipsky (1980) as he pointed out that, well designed health policy is not a guarantee for successful implementation and impact since administration willingly or unwillingly may tweak it or temper with it. The possible administrative attitudes constraints explained by scholars and different theoretical frameworks highlight the most common factors

behind administrative tempering of health policy as time, resource and information constraints (Lipsky, 1986), lack of control and monitoring (Pressman and Wildavsky, 1973), lack of knowledge and power (Long, 1992), managerial failure and lack of political will (Juma and Clarke, 1995; Sutton, 1999), complexities of implementation and management and resistance to change (Crosby, 1996; Thomas and Grindle, 1990), health policy and implementation divide, especially, in the linear view (Thomas and Grindle, 1991), the urge and endeavour to simplify complex things, often with help of narratives and discourses (Sutton, 1999), political pressure (Sabatier and Mazmanian, 1980), agency power (Long, 1992) and unmanageable number and variety of implementing agents (Verhoest et al., 2012). Thus, the aspects of administrative attitudes which have focused on in the light of these common factors include lack of knowledge and power, managerial failure and lack of political will as well as political pressure.

Bureaucratic values regarding community involvement include both managerial attitudes toward the value of community participation and administrative practicality (Kropf et al., 2012). Bureaucratic realities require managers to consider the administrative practicality of community involvement in terms of resources required, the institutional capacity needed and the potential barriers. Barriers have been attributed to both community and administrators. Communities are often criticized as lacking competence, expertise, skill, interest, and time for meaningful participation (Long, 1992). Those who regularly participate often promote their own agenda and, therefore, are not representative of the entire community. Administrators are often criticized for promoting their own agendas as well as their unwillingness to share power. In addition, administrators may lack the time and

financial resources that are necessary for meaningful community involvement to take place (Lipsky, 1986).

1.3 Statement of the Problem

Decentralization is a common approach to reach rural and urban development in Tanzania. The government has always wanted to give more power to their people and to involve them in the development process (Ngwilizi, 2001). A sort of decentralization in Tanzania was first introduced during the colonial period, at that time the independent local institutions were administered under a colonial local government. Since then, the decentralization has been progressing back with the failures in the matter of local involvement.

Decentralization has been conceived as the instrument of local self-governance for promoting health development (Islam, 2003). It is expected to facilitate effective peoples' participation, enhance degree of transparency and ensure greater accountability. Decentralization is assumed to provide more effective and competitive delivery of health services at the grassroots level. Being closer to the people, decentralization is assumed to meet the needs and preferences of the people (Crook, 2003; Bardham&Mookherjee, 2000).

Indeed, the decentralization of health service that is practised through Health Sector Reform (HSR) gained much appreciation from scholars (Mujinja and Kida, 2014; Chotara and Tumusiime, 2004). It is said, for instance, that under decentralization of health service people could enjoy greater equity and quality of health, obtain greater value for money through cost effectiveness and improve functioning and

performance of health systems (Cassel and Janovsky, 1996; Mujinja and Kida, 2014).

Community participation is regarded as an important tool for successful health sector development and it has been talked about since the mid-1950s (Guijt I, et al., 1998; Nelson N, 1995). It is advocated for providing a mechanism for potential beneficiaries of health services to participate in the plan, implementation, and evaluation of activities, with the aim of increasing sensitivity, sustainability, and efficiency of health services (Kumar S, 2002; Oakley P, 1991).

Despite having various efforts to ensure there is effective community participation in delivery of decentralized health services in Tanzania, the level and status of community participation in the delivery of decentralized health services are not realized to the intended goals of providing reliable health services to local communities. Foristance, Kessy (2014) investigated community participation in health governance structures in Tanzania, and observed that, health facility service boards are established under prevailing laws, which include Local Government Act of 1998, in sections 76, 78, 44 and 45 for District and Urban Councils. More so, the amended Act number 6 of 1996 gives legal mandate for LGAs to establish these boards. Moreover, a study conducted by Marijani (2017) indicated that, there was minimal community participation in the health boards and committees as reported in Ulanga DC and Kinondoni MC. Generally, their findings concentrated much on community participation in health governance structures and left out the impact of administration attitudes on community participation; consequently this is what triggered the undertaking of this study as the key research issue. Therefore, it is against this backdrop which motivated this study focuses on the assessment of

impact of administrative attitudes on community participation in the delivery of decentralized health services in Tanzania; a case study of Babati Town Council.

1.4 Objectives of the study

1.4.1 General Objective

The general objective of this study was to assess the impact of administrative attitudes on community participation in the delivery of decentralized health services in Tanzania.

1.4.2 Specific Objectives

i. To identify the impact of administrative beliefs on the community's provision of labuor and materials in the health facilities in Tanzania;
ii. To examine the effect of administrative perception on the community's identified health needs and preferences for human resources, adequate drugs and funds in Tanzania;
iii. To analyze the influence of administrative behavior on the community's selection of technology and the location of medical equipments in Tanzania;
iv. To evaluate the role of administrative feelings on the community's contribution of capital and operations for physical factors in Tanzania.

1.5 Research Questions

i. What is the impact of administrative beliefs on the community's provision of labor and materials in the health facilities in Tanzania?
ii. What is the effect of administrative perception on the community's identified health needs and preferences for human resources, adequate drugs and funds in Tanzania?

iii. What is the influence of administrative behavior on the community's selection of technology and the location of medical equipments in Tanzania?

iv. What are the role of administrative feelings on the community's contribution of capital and operations for physical facilities in Tanzania?

1.6 Significance of the study

This study will intend to provide relevant data or information on the impact of administrative attitudes on community participation in the delivery of decentralized health services. The findings of this study will serve as a conceptual framework for policy makers and implementers in Babati Town council in particular and Tanzania in general, and on the other parts of the world where similar study could be adopted. Also, the study will influence community awareness on importance of the delivery of decentralized health services towards the improvement of community participation as well as improvement of health service delivery. Meanwhile, the study is very potential for the researcher for the Partial fulfillment for the requirement of Master's Degree of Public Administration (MPA) of the Dodoma University.

The concentration of this study is in administrative attitudes on community participation as well as decentralized health service delivery. In fact, the study will help to improve the participation of local communities in terms of health service delivery because the study informs the community, ward authorities, ministry and other stake holders on how to improve the programmes such as when local communities are given powers and capacity building consequently will improve the delivery of health services.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This Chapter is about literature related to the study. The evaluation of the theoretical literature review, conceptual framework as well as empirical literature review, starting with definitions of the most valuable terminologies that were used in this study regarded to the impact of administrative attitudes on community participation in the delivery of decentralized health services. Purposely, the section made critical review of the literature intended to gene rate the knowledge gap for the study.

2.2 Definition of Key Terms and Concepts

This part includes the definition of key terms and concepts that was used in this study.

2.2.1 Community

Community is small or large social units who have something in common, such as norms, religion, values, or identity. Communities often share a sense of place that is situated in a given geographical area such as a country, village and town or in virtual space through communication platforms (James et al., 2012). Moreover, in social perspective, a community can also be defined by describing the social and political networks that link individuals, community organizations, and leaders (Minkler et al., 1997).

2.2.2 Community Participation

Community participation is commonly understood as the collective involvement of local people in assessing their needs and organizing strategies to meet those needs

(Zakus and Lysack, 1988).On the other hand, Community participation is defined as community involvement or partnership between individual groups, organizations and health professionals in health and health activities (WHO, 1995). Groups are empowered to express their rights to be active in the development of suitable health services.

In this study, community participation refers to the people's involvement or participating together in advisory groups, fundraising, attending consultations, planning and the interventions from government, Non-Governmental Organizations (NGOs) or other external organizations concerning to health services in local areas.

2.2.3 Decentralization

Decentralization refers to those legal acts and administrative measures that initiate a transfer of responsibility (authority), resources (human and financial), accountability and rules (institutions) from central government to local entities (Olowu and Wunsch, 2004).

According to Mills (1990), decentralization takes many forms, but from public administration four forms are commonly found in practice as shown below;

2.2.3.1 Deconcentration

Deconcentration is where administrative responsibilities are transferred to locally-based office of a national government ministry. The office remains accountable to higher level government (Mills, 1990).

2.2.3.2 Delegation

Delegation is where management responsibility is transferred to a semi-autonomous entity such as a health board. The purpose is to free national government from day to day management functions. Again, the entity remains accountable to national government (Mills, 1990).

2.2.3.3 Devolution

Devolution is where political and administrative authority for service delivery is transferred to an independent local-level statutory agency, for instance a municipal council. The local organization is able to generate revenue due to its statutory status. In this case accountability remains to the electorate (Mills, 1990).

2.2.3.4 Privatization

Privatization is where service or functions are transferred to a private (profit or non-profit) entity with the aim of improving the quality through user participation and competition, and to improve efficiency. In this aspect, the government retains some regulatory and overall coordination. And therefore, the services are accountable to the government and service users (Mills, 1990).

2.2.3.5 Decentralized health

Decentralized health has been conceived as the instrument of local self-governance for promoting health development (Islam, 2003). It is expected to facilitate effective peoples' participation, enhance degree of transparency and ensure greater accountability.

Decentralized health is assumed to provide more effective and competitive delivery of health services at the grassroots level (Crook, 2003). Being closer to the people, decentralization is assumed to meet the needs and preferences of the people.

2.2.4 Health Service

Health service means a service that provides medical treatment and care to the public or to a particular group (Scholle et al., 2010).

In this study, health service means services provided to the community for eradication, treatment and cure of diseases.

2.2.5 Community Participation in Health

The concept of community participation is sometimes mentioned as citizen or consumer involvement. In health this concept is defined by (Zakus and Lysack 1998) as a process in which members of the community collectively with different efforts are able to assume great responsibility for identifying their health needs and problems, plan and act to implement their solutions, and also keep in support of their organizations effort, and lastly evaluate the effects then bring about necessary adjustments in the programme as an on-going process. In this study, community participation in health means involvement in decision-making about the type of healthcare services.

2.2.6 Administrative attitudes

Attitudes are usually viewed as a kind of disposition toward various aspects of the world including persons, events and subjects. It has been commonly believed that attitude change is necessary before other behavioral modifications can be effected (Zainuddin, 1977). Allport (1935) defined attitudes as a mental and neural state of

readiness, organized through experience exerting a directive or dynamic influence upon an individual's response to all objects and situations with which it is related. Tosi and Mero (2003) explain that attitudes can be understood more easily if they are viewed as components and dynamics. Administrative attitudes are the attitudes of the administrators who are supposed to carry out the policy. An administrator who is not committed to a policy can either simply ignores it; otherwise if the policy seems threatening, actively work to sabotage it. In the final research it is the administrator in the field who must act as the lightning rod in the linking of policy planning in the center to policy implementation in the rural district. In this study, administrative attitudes means something that decision makers can predict and control the behavior, which ultimately is useful to implement health program successfully.

2.2.6.1 Beliefs

Belief is the state of mind in which someone thinks something to be the case with or without there being empirical evidence to prove that something is the case with factual certainty. Another way of defining belief sees it as a mental representation of an attitude positively oriented towards the likelihood of something being true (Primmer, 2018). In this study, beliefs mean administrative negative way towards community involvement in the decentralized health services. It is a component of attitudes.

2.2.6.2 Perception

Perception is closely related to attitudes. Perception is the process by which organisms interpret and organize feeling to produce a meaningful experience of the world (Lindsay & Norman, 1977). Likewise, a person is confronted with a

circumstances or motivation. The someone interprets the stimuli into something meaningful to him or her based on prior experiences. Though, what an individual interprets or perceives may be considerably different from reality. In this study, perception means administrative negative way towards community involvement in the decentralized health services. It is a component of attitudes.

2.2.6.3 Behaviour

Behaviour refers to every action by a person that can be seen or heard. Behaviour must be defined in a way that is both observable and measurable so that everyone has a good understanding of what the behaviour looks like (Alberto & Troutman, 2003). In this study, behaviour means administrative negative way towards community involvement in the decentralized health services. It is a component of attitudes.

2.2.6.4 Feelings

In Psychology (Vandenbos, 2007) and Philosophy (Solomon, 2004), feelings notion is frequently used to comprehend conscious and subjective experience of emotions. In this study, feelings mean administrative negative way towards community involvement in the decentralized health services. It is a component of attitudes.

2.2.6.5 Labour

The labour force participation rate is a measure of the proportion of a country and their working age population that engages actively in the labour market, either by working or seeking for work. It provides an indication of the size of the supply of labour existing to engage in the production of goods and services relative to the population at working age (ILO, Geneva, 2005).

2.2.6.6 Funds

Funds are the financial resources, usually in the form of money, or other values such as effort or time, to finance a need, program, and project, usually by an organization or company. Generally, this word is used when a firm uses its internal reserves to satisfy its necessity for cash (Forbes, 2011).

2.2.6.7 Health Technology

Health technology is defined by the World Health Organization as the application of organized knowledge and skills in the form devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives (WHO, 2015). In this study health technology means application of science in health services intended to improve provision of quality of care.

2.2.6.8 Health Facilities

Health facilities are places that provide health care. These include hospitals, clinics, outpatient care centers, and specialized care centers, such as birthing centers and psychiatric care centers. Also, a health facility is, in general, any location where healthcare is provided. Health facilities range from small clinics and doctor's offices to urgent care centers and large hospitals with elaborate emergency rooms (Ahmadi-Javid, A, 2017).

2.2.6.9 Medical Equipments

These are capital equipment and durable items that last for several years, such as beds, examination tables, sterilizers, microscopes, weighing scales and bedpans (Kaur and Hall, 2001).

2.3 Theoretical Literature Review

These are grand theories or ideas which act as an internal structure of the study. This structure purposely gives the study a logical frame or a logical explanation, particularly because, most studies are only additional to the already existing body of knowledge and they are not the first ones. It is also to establish a theoretical link between independent and dependent variables. The study was based on three theories, namely social exchange, principal-agency and the social capital theories.

2.3.1 Social exchange theory

This theory states that people develop attitudes toward others and things based on the benefits they could obtain while those activities assuming to increase benefits will be positive support and activities assuming to be costly will tend to be perceived negatively (Napier & Napier, 1991). Social exchange theory stress that all human relations are formed by the use of a subjective cost benefit analysis. In favor of social exchange, when the costs and benefits of a relationship are equal the relationship is defined as equitable. In social exchange theory the concept of equity is fundamental. Participation occurs when the cost of participation is low and the benefit of participation is high, and consequently it makes positive attitude toward participation in decentralized health services delivery. But if the cost outweighs the likely benefits, there is no interest for participation in decentralized health services delivery. According to this study, the social exchange theory is used to illustrate that citizens assess their interaction and cooperation in health services delivery with administrative attitudes based on benefits including availability and access to health facilities, medical equipments and funds as well as costs such as inadequate of access to health services that bring inequality in community health.

Prekumar and Ramamurthy (1995) declared that social exchange theory has been used by some researchers as a theoretical framework to investigate the community relationships that are not based on the economical characteristics, rather than they are based on non economical aspects, such as power, trust, interdependency, and the like. Thus, this hypothesis is not only for exploration of the economic relations, rather it can be used for study of non economic and social relationships. It is stated that social exchange theory provides the base for the study of relationships between groups and organizations in community (Prekumar and Ramamurthy 1995). According to social exchange theory, the outcomes of a collective or organization's behavior will be related to the responsive behavior of the other participants within the relationship (Son et al. 2000). The main issue of this perspective is that the relationship between community groups does not necessarily need to be directly related to any economic outcomes (Hallen et al. 1991, Humphreys et al. 2001): Humphreys *et al.,* (2001) postulate that social exchange theory is an appropriate base for studying non-profit relationships. So, in terms of people's participation in local government, the social exchange theory is adopted to investigate the social aspects of relationships between community and local government.

The important criticism of social exchange theory; however, is that it lacks sufficient theoretical precision, and thus has limited utility. Scholars who pertain social exchange theory are able to explain many social phenomena in post hoc manner but are severely limited in their ability to make useful a priori prediction regarding workplace behavior.

The theory is reductionist (reducing something to very few factors), explaining human interactions only in terms of costs, rewards, profits and exchanges leaves out

a lot of other factors that impact human exchanges. Since its preliminary introduction, much of the branching out of the social exchange theory tree involves adding complexity to the theory. Consequently, other concepts such as social structure, power, trust, motives, environment/context, relationship, and time have become part of various models of social exchange theory. The elaboration of social exchange theory notably reduces the claim of the theory being reductionist.

2.3.2 Principal-Agency Theory

The study is guided by the Principal-Agency theory to explain the participation of the community in the delivery of the health services. The theory recognizes the role of multiple levels and different actors and locates each actor at the appropriate level (Mandara, 2014). In the context of decentralization, there is agency relationship where local governments act as the agent of the two different principals: the central government and service users (Masanyiwa, and Anke, 2013).

The theory is very useful here as it focuses on both the relationships between actors in decentralized institutions and the duties and responsibilities imposed on the actors by decentralization reforms (Hiskey, 2010). It helps to view health ministry as the principal intending to improve service delivery rather than profit maximization. The theory has the benefit of focusing on the relationship between the centre and the periphery and sees the relationship as dynamic as well as evolving, and therefore, relying on the mechanisms at the centre. The hypothesis can shape the choices made at the periphery. In fact, decentralized primary health care services delivery is organized at central and local government levels in Tanzania. Therefore, Principal-Agent Theory is considered necessary for an orientation of this study.

The principal agent approach comes from the economic sciences. In research it is often used to analyze intergovernmental transfers, the bargaining between local and central levels of government, and in the field of health care also for the research of provider patient relationships (Bossert 1998: 1516). Silverman distinguishes between top-down and bottom-up principal agency (Silverman 1992: 2). In the context of top-down principal agency, local governments exercise responsibility on behalf of central governments or parastatals. In the "bottom-up" principal agency model, various levels of government or government parastatals act as agents of lower level of governments or directly as agents of beneficiaries/ users/ clients (Ibid.). Most of the literature only reflects the "top-down" principal agency, where the principal is an administrative agency at the centre, which delegates, through legislation or contract, to a local-level governmental or private sector institution or organization (the agent) the authority to deliver health care to the citizen beneficiaries (client). (Cohen Peterson 1997). Thus, the principal uses the agent for the implementation of its objectives. Agents usually have other interests and more information than the principal. The principal has to generate incentives for the agent in order to ensure its cooperation and the delivery of information. Control of information and improved monitoring are central issues in this approach. In health care the Ministry of Health or the district health authority could be the principals who use local authorities or medical officers as agents. The approach sees these relationships as dynamic and assesses how performance is monitored and incentives and punishments are shaped (Bossert 1998). The "bottom-up" principal agency incorporates the idea of community participation. Although actual examples of this approach are rare, some attempts to use this approach in primary health care have been encouraging (Silverman 1992).

Major criticism to this is that, sometimes people resist the pressure to obey authority, because of individual differences. His theory fails to explain why some people are more likely to exhibit independent behaviour than other and thus is reductionist because it ignores the role of other factors, such as individual differences.

2.3.3 The Social Capital Approach

The social capital approach was introduced in decentralization studies by Putnam (Putnam 1993). He links better institutional performance of decentralized governments to the density of local institutions. For Putnam the density and belief of local institutions in an area create expectations, experiences and trust among the local population which forms the social capital. Social capital, thus, generates more participation of the local population and, therefore, fosters accountability. Bossert adopts his approach to health care, suggesting that localities with long and deep histories of strongly established local organizations will have better performing decentralized governments than localities which lack these networks of associations (Bossert, 1998). But he also criticizes Putnam's approach for the lack of policy relevant conclusions. The social capital approach does not allow assumptions about areas with no local institutions, despite the insight that decentralization will not work there. Since developing countries rarely have a history of strong local institutions, this theory is not politically viable. However, Atkinson proposes to use Putnam's findings for researching the influence of local social organizations and political culture (Atkinson, 2000).

The main criticisms of social capital approach are that it is not social, not capital, and not a theory. This does not leave the concept with much of substance, leading

some authors to describe the concept as fundamentally flawed. Additionally, it has been claimed that it is impossible to measure, that problems of circularity make it a tautology, and that the possibility for positive or negative outcomes make it context dependent. Some aspects are objective, but others are subjective. Some are cognitive, but others are pre-cognitive. Social capital can be logical, pre-logical, or even non-logical. This suggests social capital is more of an umbrella concept than a functioning approach.

A justification as to why the use of three theories in this study is due to the fact that the theoretical literature review presupposes their several theories to explain both independent and dependent variable.

2.4 Empirical Literature Review

The purpose of this part is to deliberately document, critically evaluate, and summarize scientifically some of the empirical studies about the research problem in the section. Normally, it focuses on a very particular empirical question, often posed in a cause and effect form.

Community participation in the delivery of decentralized health services has got problems in Tanzania and elsewhere. However, there are many studies done so far regarding the issue giving rise to several explanations.

2.4.1 Adequacy Resources and budget

A study conducted by Okojie, (2009) researched on decentralization and public service delivery in Nigeria. However, the finding showed that, first, there is the over-concentration of political and financial power as well as human resources at the federal level to the detriment of state and local governments. Second, there are

inadequate finance and insufficient tax power bestowed on local governments. Third, decentralization in Nigeria has limited the powers of local government on budgeting and staffing. Fourth, there is no set minimum standard for quality, quantity, and access from central government for local government to adhere to. Fifth, there is a lack of human resources in local governments (Okojie, 2009). Therefore, according to the above challenges and causes this study focuses on the assessment of impact of administrative attitudes on community participation in the delivery of decentralized health services.

2.4.2 Effectiveness of Health Committees

A number of studies suggest that health committees in South Africa are not functioning optimally (Boulle et al, 2008; Padarath and Friedman, 2008; Glattstein-Young, 2010). Numerous factors have been identified as impacting negatively on the successful functioning of health committees. These include lack of political will, limited resources, limited capacity and skills, attitudes of health workers, lack of clarity of the role and mandate of committees, limited co-operation from health services, and lack of support (Padarath and Friedman, 2008; Glattstein-Young, 2010). Finally, Boulle's study (2007) points to the importance of socio-economic context, arguing that poverty and inequality inhibit effective community participation as well as effective health committee functioning.

2.4.3 Quality of Delivery of Health Services Delivery

Angeyo et al., (2008) conducted a study on citizen participation and health service delivery in Uganda. The study assert that since the end of the liberation struggle in 1986, the NRM government tried hard to bring services closer to the people and to improve the well-being of every Ugandan through constitutional reforms. The

government took a democratic participation approach to address the health care service delivery challenges by undertaking an extensive decentralization of the public sector and adopting a new national health policy. Despite of the strategies taken by the government to improve delivery of health services, this study showed that, there were high shortages of health officers in the health centers as the centers met only 34% of the total requirements. Due to weak organization of delivery of health services even the status of community participation constituted only 45% in Uganda.

2.4.4 Corruption and negligence

Mpambije, (2016) investigated on decentralization of health service provision in Tanzania. The study revealed that, the grim situation in LGA's provision of health services has largely been exacerbated by corrupt practices by public servants. Corrupt practices at the LGAs disproportionally affect the poor access to health service. Similarly, Mzenzi and Gasper, (2015) underscored further that mismanaging of LGA in Tanzania takes different forms across the LGAs being engrained with negligence and self-interest behavior.

2.4.5 Procurement and contract management

The study conducted on availability of medical equipments, drugs and materials in Tanzania by (ALAT, 2011). The study revealed that, there were many problems with procurement and contract management, such as procurement of goods and services without the approval of the tender board, procurement of services from unapproved supplier, procurement without competitive bidding, the value of stores not being recorded in the ledgers, goods paid for but not delivered and inadequate documentation of health projects and contracts.

2.4.6 Accountability and political will

This study shows the inability of poor people to hold LGAs staffs' accountability (ALAT, 2011). Above all, Afrobarometor (2005) observed that, citizen had no ways to hold their representatives accountable for their actions and councilors had limited power to remove non-performing council officers.

There is a growing body of evidence that the lack of political will among the LGAs impairs much delivery of health services since it affects greatly possible implementation of set plans and policies (Esan *et al.,* 2014; Melena, 2009). Political will is a commitment of actors mostly bureaucrats and politicians to undertake actions to achieve set objectives and sustain the cost of those actions over time (Amundsen & Mathisen, 2006). Lack of political will has not only affected decentralized health services, but also other sectors. Couzen & Mtengeti (2011) realized that the failure of creating space for child participation in local governance was indeed due to lack of political will as LGAs failed to allocate budget for child participation. In Nigeria also, lack of political will among the LGAs staff has affected delivery of health care particularly maternal and child health (Esan, *et al.,* 2014). Inadequate political will on the part of LGAs was identified as a root cause of performance gap for maternal and newborn health services in South West Nigeria Esan, *et al.,* 2014). Berry *et al.,* (2004) assert that where political will is lacking, certain groups may be deliberately excluded from social services on the basis of gender, ethnicity, religion, caste, tribe, race or political affiliation.

2.4.7 Utilization of the allocated fund from the Central Government

The goals of decentralization of health services under HSR, according to Cassel and Janovsky (1996) and Mujinja and Kida (2014), included: to improve health status

and consumer satisfaction by increasing the effectiveness and quality of health services; and to obtain greater equity by improving the access of disadvantaged people to quality care. Other goals were to obtain greater value for money through cost effectiveness from health spending and the management and use of the resources that have been allocated. Also, improve the functioning and performance of health systems and consequently improve the quality and quantity of health service. For some time now, not all anticipated benefits are attained by the LGAs as health related programmes that are funded by the CG and implemented by the LGAs face severe problem, chief of it being poor utilization of the allocated fund from the CG. This, in essence, has far reaching impact to a type of health care to be provided.

2.5 Knowledge gap

Having the analysis of the literature reviewed, there is still a gap in knowledge concerning the investigation on the impacts of administrative attitudes on community participation in the delivery of decentralized health services. However, despite having various efforts to ensure there is effective community participation on delivery of decentralized health services by different scholars but their findings concentrated much on community participation in health governance structures and left out the impact of administration attitudes on community participation in the delivery of decentralized health in Tanzania (De Palencia, 2010). Therefore, this is what motivated the pursuit of this study sought to uncover.

The concentration of this study is in communities and administrative attitudes including beliefs, perceptions and behaviors in Babati Town Council to see the impacts made by the government to ensure availability of health facilities, adequate drugs and funds, human resource and medical equipments for better delivery of

decentralized health services. The knowledge to be discovered in this study is to find out if acknowledging administrative attitudes on community participation and improving decentralized health services can act as a coping strategy to overcome some challenges like those of poor medical equipments supply, poor health facilities, inadequate staff, drugs, funds and other local governments' administrative problems.

2.6 Conceptual Framework

A conceptual framework is a scheme of concepts or variable which the researcher will use in order to guide the study (Oso and Onen, 2008). Basically, it is a diagrammatic presentation of a theory. The illustration of the framework should seek to show the linkage and the relationship between variables, namely independent and dependent variables. The framework shows that dependent variable is affected by independent variable and other variables.

According to this framework, the social exchange theory is used to illustrate that citizens assess their interaction and cooperation in health services delivery with administrative attitudes based on benefits including adequate to health facilities, physical facilities, medical equipments, human resources, drugs and funds as well as costs such as inadequate of access to health services that bring inequality in community health.

It declared that social exchange theory has been used by some researchers as a theoretical framework to investigate the community relationships that are not based on the economical aspects, rather than they are based on non economical characteristics, such as power, trust, interdependency, and the like (Prekumar and Ramamurthy 1995). Therefore, this theory is not only for investigation of the economic relations, rather it can be used for investigation of non economic and

social relationships. Furthermore, Prekumar and Ramamurthy (1995) stated that social exchange theory provides the base for the study of relationships between groups and organizations in community (Prekumar and Ramamurthy 1995). According to social exchange theory, the product of a collective or organization's behavior will be related to the responsive behavior of the other participants within the relationship (Son et al. 2000). The main issue of this perspective is that the relationship between community groups does not necessarily need to be directly related to any economic outcomes (Hallen et al. 1991, Humphreys et al. 2001). Humphreys et al. (2001) postulate that social exchange theory is a suitable base for studying non-profit relationships. Thus, in terms of group participation in local government, the social exchange theory is adopted to investigate the social aspects of relationships between people and local government.

2.6.1 Administrative Attitudes

Administrative attitudes are manifested through beliefs, perception, behaviour and feelings.

2.6.1.1 Administrative Beliefs

Beliefs are components of attitudes; these play a big role in affecting community participation in the delivery of decentralized health services. In this study the attitude towards community participation would be measured in relation to administrative beliefs, as there is a close link between attitude and beliefs. This reality is agreed by Anderson (1972) where he concluded that these are closely linked and any change or addition in one or more beliefs usually produces a change in attitude.

2.6.1.2 Administrative Perception

Perception is among the components of attitudes; this has a big role in affecting community participation in the delivery of decentralized health services. Perception is closely related to attitudes. Perception is the process by which organisms interpret and classify awareness to produce a meaningful experience of the world (Lindsay & Norman, 1977). The person interprets the motivation into something meaningful to him or her based on past experiences. However, what an individual interprets or perceives may be significantly different from reality. There is a close link between attitude and perception, any change or addition in perception usually produces a change in attitude.

2.6.1.3 Administrative Behavior

Behavior is among the component of attitudes; it affects community participation in the delivery of decentralized health services. Alfred Adler (1870–1937), a Viennese physician who developed the theory of individual psychology, emphasized that a person’s attitude toward the environment had a significant influence on his or her behavior.

2.6.1.4 Administrative Feelings

Feelings are amongst the components of attitudes; these also play a big role in affecting community participation in the delivery of decentralized health services. According to Allport (1935); the feeling and belief components of attitudes are internal to a person, we can view a person’s attitude from his or her resulting behavior.

2.6.2 Community participation on the delivery of decentralized health services

2.6.2.1 Community's selection of technology and the location of medical equipments;

Delivery of quality health services requires availability of functioning basic equipment. The World Health Organization (WHO) and the United States Agency for International Development (USAID) have proposed a list of seven basic pieces of equipment that should be available at a health facility to guarantee its willingness to deliver fundamental health services (WHO, 2012). These include an adult scale, a child scale, an infant scale, a thermometer, a stethoscope, blood pressure apparatus, and a light source. They consist of the basic equipment domain for assessing general service readiness.

According to Tanzania Service Provision Assessment Survey (TSPA) a stethoscope (91 %) is the most commonly available piece of basic equipment, followed by a thermometer and blood pressure apparatus, each of which is found in about eight of ten facilities, and an adult scale found in 76 percent of facilities(TSPA, 2014). In contrast, only 38 percent and 16 percent of facilities have an infant scale and light source, respectively. Government managed facilities are less possible to have a light source (10 percent) than other managed facilities (26 to 32 percent). Blood pressure apparatus is likely to be available in all types of facilities, with availability ranging from 81 percent in dispensaries to 92 percent in hospitals. The availability of a light source is lower in dispensaries, 12 percent have a spotlight source or functioning flashlight equipment than other types of facilities (27 to 48 percent). Basic equipment to support quality health services are more likely to be available in urban

facilities than in rural facilities, with the exception of child and infant scales which are more commonly available in rural facilities(TSPA, 2014).

This context in Tanzania experiences there is minimal community participation in the selection of technology and location of medical equipments.

2.6.2.2 Community's provision of labor and materials in the health facilities;

Hypothetically, good health services can be provided even in minimal service delivery settings. However, the availability of basic amenities such as regular electricity, an improved water source, visual and auditory privacy, a client latrine, communication equipment, a computer with internet access, and emergency transport are important for client satisfaction with the services rendered at health facilities. These indicators comprise the *basic amenities* domain for assessing general services, as proposed by WHO and USAID (WHO, 2015).

The most commonly available client amenity in Tanzania was visual and auditory privacy in the service area, available in over 90 percent of facilities. Availability of other amenities in Tanzanian health facilities ranges from 68 percent with improved water source and 67 percent with access to regular electricity to 12 percent with a computer and Internet access. Dispensaries 65 percent are less probable than other facility types to have an improved water source. By managing authority, government facilities are generally less probable than facilities managed by other authorities to have an enhanced water source. Urban amenities 84 percent are more probable than rural amenities 62 percent to have an enhanced water source.

In general, about two-thirds of all facilities have access to regular electricity (compared with one-third in 2006). As expected, hospitals (91 percent) are more

likely to have regular electricity than other facility type's health centers (76 percent), clinics (70 percent), and dispensaries (65 percent). The availability of regular electricity shows some regional variation; it is highest in Kigoma region (99 percent) and lowest in Shinyanga region (45 percent). About six of ten facilities have emergency transport. Hospitals (93 percent) and health centers (74 percent) are more likely than dispensaries (54 percent) and clinics (29 percent) to have emergency transport. By managing authority, private for profit amenities are less probable than facilities managed by other managing authorities to have emergency transport.

A client latrine is available, on average, in 44 percent of facilities. Clinics (93 percent) and hospitals (76 percent) are more likely to have a client latrine than other facility types. The least available amenity is a computer with Internet connectivity, available in only 12 percent of facilities. Hospitals are more probable to have a computer with Internet access than other facility types. Only 7 percent of government facilities have a computer with Internet access, mainly because the large proportion of government facilities are dispensaries. Almost all basic amenities are more available in urban facilities than rural facilities, except for the availability of emergency transport (51 percent in urban areas compared with 60 percent in rural areas).

This context in Tanzania experiences there is minimal community participation in the provision of labor and materials in the health facilities.

2.6.2.3 Community's identified health needs and preferences for human resources, adequate drugs and funds;

Amongst the eight MDGs, four explicitly discuss the availability of medicines at the primary care or service delivery point level (UN, 2012). It is relevant because without access to and suitable use of quality medicines, health systems would lose their ability to meet healthcare needs. However, affordability of medicines and high prices are regularly highlighted as challenges to access to essential medicines, the weakness of health supply chains have remained a consistent barrier across a range of low and middle-income countries (UN, 2012; Matowe, *et al.*, 2008). Despite major investment over the past decades, general supply chains are frequently unable to respond effectively to existing demands, putting health outcomes at risk.

As the first Global Forum on Human Resources for Health in Kampala in 2008 (FGF, 2008), the human resource focus has been on the doctors, nurses, midwives and community health workers. Still, there is little focus on human resources to improve and maintain health supply chains. A focus on the human resources is needed and in this context, in 2011, the People that Deliver (PtD) Initiative were founded. Launched in 2011, the PtD Initiative is a global partnership of over 80 organizations that have the joint vision of a world where an agenda for national health supply chain workforce is developed. (www.peoplethatdeliver.org).

The International Pharmacy Federation (FIP) provided further evidence of the need for a Human Resources focus in Supply Chain Management through their Global Workforce Report in 2012 (FIP , 2012). In that report they make a linkage between a lack of pharmacy personnel and inequalities in access to medicines. For example in Sub-Saharan Africa, on average less than one pharmacist was observed for caring

10,000 populations. In October 2014 the 2nd Global Conference on Human Resources for Supply Chain Management (SCM) was held to demonstrate the achievement PtD has made in the recent years [www.peoplethatdeliver.org].

Human resources are a key performance driver within community health supply chains. The successful management of a supply chain demands excellence in managing its human resources, an area particularly overlooked in resource poor environments. By proactively managing plans, policies and procedures associated with people, an organization can improve supply chain performance. Such a logical approach requires the need to plan, finance, develop, support, and maintain the national workforces needed for the effective, efficient, and sustainable management of health supply chains.

The second PtD International Conference on Human Resources in Supply Chain Management Conference presented international and country based work around five interrelated sub themes. The abstracts presented in this particular issue emphasize current universal activity in this area and lay the foundation for the second phase of PtD 2015-2016. Some of the themes presented in the conference include, the increasing use of the HR for SCM assessment tool, application of SCM competency modeling varied approaches to SCM workforce development and local professionalization activities.

Since the post 2015 development agenda moves its focus toward health equity, the world's increasing population and expanding middle class will place even greater demands on health services. These rising demands will put further strain on the health supply chains required to offer these services. In resource limited

environments the challenge will be to provide a business case to governments, convincing them of the need to invest in health supply chains. The international development agenda will require organizations involved in health supply chains to come together in a more coordinated fashion, working with governments to enact local, sustainable change. The People that Deliver program will continue to provide a platform to guarantee that HR for SCM remains on the international agenda.

Tanzania spends a mix of financing sources to support its health scheme, which largely relies on taxes. A tax is complemented by user fees where patients contribute to the costs of their health services. MoHSW has introduced three insurance schemes: the Community Health Fund (CHF), TIKA (for urban, peri-urban areas), and the National Health Insurance Fund (NHIF). The government has finalized its Health Financing Strategy (HFS), which focuses on universal and equitable access to essential health services. A key barrier to improved quality and access is the lack of effectiveness and efficiency in health financing (TSPA, 2014).

The Health Basket Fund plays a crucial role in health care financing, although, in recent years, contributions from development partners are declining. These finances offer the LGAs opportunities for implementing service delivery. The demands and capacities in LGAs for timely accounting and reporting do not always match the requirements. However, financial decentralization is aimed at conferring autonomy to health facilities on financial management.

According to TSPA, (2014), the availability of key medicines in health facilities remains low. A number of factors (internal and external) affect overall management of commodities in the health sector. According to the BRN research, internal factors

comprise inadequate funding, poor planning and coordination, inadequate tracking mechanisms and tools, as well as inadequate pharmaceutical human resources at the facility level resulting in poor inventory management. External factors comprise pilferage and lack of coordination of externally-funded vertical programmes that donate medicines, health products, and supplies. This negatively affects the quality of care and performance of service provision in general.

In Human Resources for Health, newly trained staffs have problems quickly finding employment, while vacancies exist. The number of health employees, especially clinical personnel is increasing. However, rural areas still face major shortages and many primary health facilities do not have enough qualified staff, resulting in an inefficient use of resources. Population ratios for laboratory and pharmaceutical human resources remain well below expectation. Critical under-financing and limitations enforcing the Public Service Pay and Incentive Policy (2010) intensify the misdistribution or shortage of health workers.

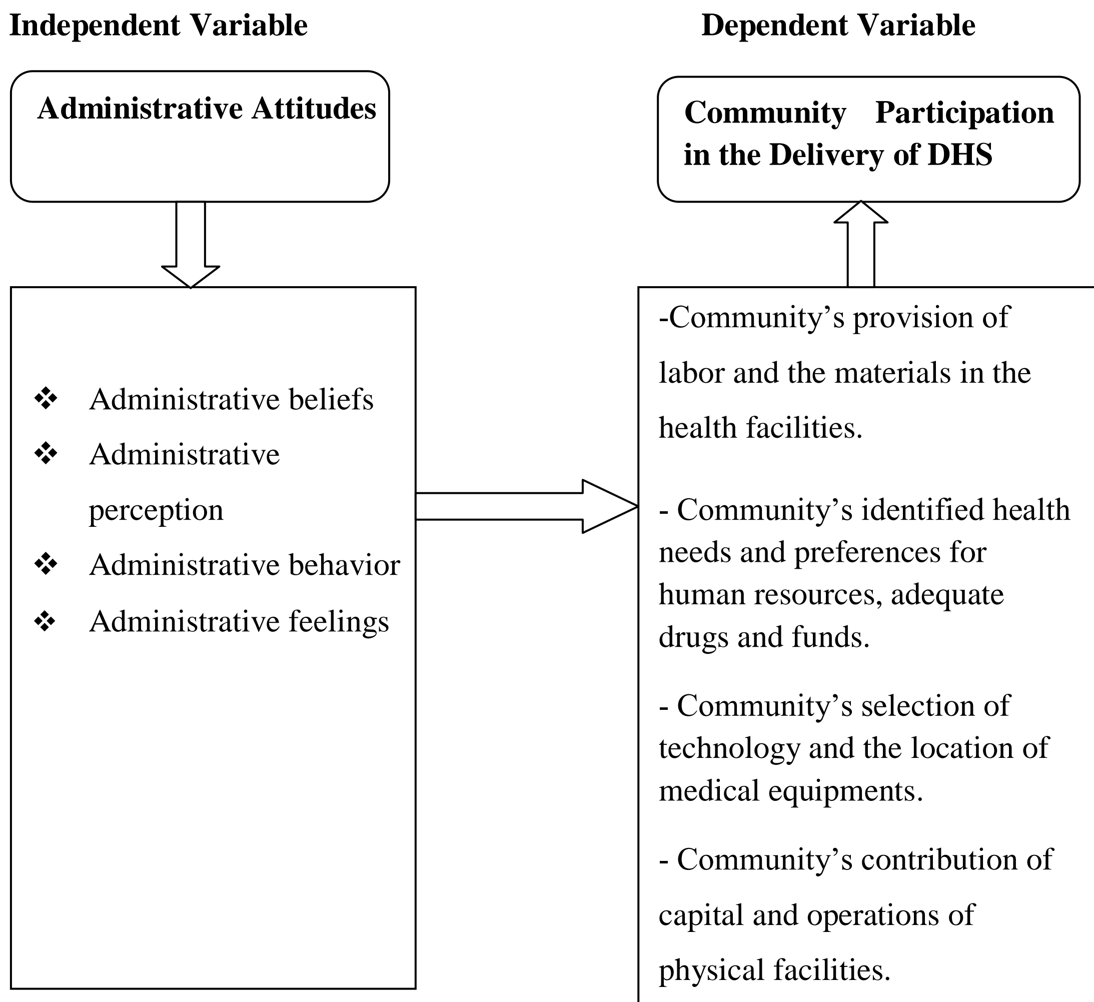
The health workforce is an integral part of the health system. W.H.O considers the health workforce to be one of the key building blocks of the health system. The 2014-15 TSPA assessed the availability of various cadres of health workers at different levels of health service delivery. This context in Tanzania experiences there is minimal community participation in the identified health needs and preferences for human resources, adequate drugs and funds.

2.6.2.4 Community's contribution of capital and operations for physical facilities

The health sector infrastructure in Tanzania is expanding, especially the number of dispensaries (2014-15 TSPA). Yet, in some regions, the number of amenities is still insufficient. Most health amenities in remote areas lack electricity and a reliable water supply. Past construction activities have exceeded the deployment of staff, leading to underutilization of the infrastructure and, thus, efficiency losses. Infrastructure repairs are a major challenge that affects most institutions. Maintenance of equipment is not yet a priority for health facilities, which has a negative impact on the effectiveness and quality of service delivery.

The above conceptual framework has been created from the theories and will guide the whole study on which if the government will have fruitful policy, planning and enough budget will raise to medical equipments, physical facilities as well as human and fiscal resources hence decentralized health service delivery will be realized.

This context in Tanzania experiences there is minimal community participation in the contribution of capital and operations for physical facilities.



Source: Researcher's construction based on literature review

Figure 1: Conceptual framework for administrative attitudes on community participation and delivery of decentralized health services.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains the methods that were used in collection and gathering of data pertinent in answering the research questions. The part specifically covers the following sub-sections: study area, research design, study approach, target population and sample frame, research instruments, the sample size and sampling procedures, data sources and methods, data collection methods and data analysis procedures. Finally, reliability and validity of data as well as ethical consideration have been employed.

3.2 Study Area

The area of study was selected simply because the council is experiencing the problem of community participation in the delivery of decentralized health services like other councils in Tanzania. This study was conducted at Babati Town Council. The Council is one of the two Councils in Babati District and of the six Councils in Manyara Region. It is a new Town council created by splitting the former Babati District council and the council was formally established in September 17th, 2004 following the Government Notice Na. 352 (URT, 2013).

Babati Town Council is located below the Equator between latitude 3° and 4° South and longitude 35° and 36° E, around Lake Babati in urban and rural areas and Babati District covers an area of 6,069 km^2 (2,343 sq m), a large proportion (640 sq km) of which is covered by the water bodies of Lake Babati, Lake Burunge and Lake Manyara and according to the National census of 2012, the 8 wards of Babati Town Council have a total population of 93,108 people, out of which 47,313 are male and

45,795 are female. Primary economic activities of people living around the study area include fishing, livestock keeping and small holder agriculture production of such crop as maize, pigeon peas, lablab beans, beans and horticulture activities (URT, 2013).

The reason for selecting the area was due to the fact that Babati Town Council is one of the urban centers with rapid development and population increase which needs sustainable delivery of decentralized health services. As the study focuses on the administrative attitudes on community participation in the delivery of decentralized health services in Tanzania; a case study of Babati Town Council, the selection of the study area was based on the councils and its administration system. However, time and monetary limits of data collection had pressed me to select the area. On the other hand, it has a good means of communication that was enable the researcher to access different places and get relevant data easily.

3.3 Research Design

Research design is a plan of action designed to achieve a specific goal (Denscombe, 2010). According to Kothari, (2004) Research design is a conceptual structure in which the research is conducted. It constitutes the blue print for the collection, measurements, analysis and interpretation of data. The strategy to be employed in the research needs to be suitable, feasible and ethical according to the purpose of the research. This study employed a case study research design. In this specific study, the case study approach is deemed important by the researcher. The case study approach gives the research a detailed and large sense of the case under investigation. The researcher gets a chance to examine and demonstrate a certain event or incident in a broad context as a whole over a certain period of time (Patton,

1990; Wiersma, 2000; Neuman 2003). Bromely (1986; cited in Cohen etal, 2000), argues that a case study gives the researcher a chance to relate closely the area of interest because of ‘direct observation’ in a normal setting. For instance, the researcher is able to get near to subjective factor like participants emotions.

The selected design was considered to be appropriate to meet the demands of research questions guiding this study, since the design allows studying all variables throughout the research objectives by employing various techniques of data collection regarding the study. Selection of choices according to this study was based on Kothari, (2004) due to the facts that it is well elaborated by the authoritative source about this study.

3.3.1 Study Approach

Research approaches are plans for research that span the steps from broad assumptions to detailed methods of data collection, analysis and interpretation (Creswell, 2003) It involves the selection of research question, the conceptual framework that has to be adopted and the selection of appropriate research method (Kothari, 2004). In this study, both qualitative and quantitative research approaches was used in order to collect data in a wide range. Quantitative approach is generally given to the study of the overall statistical results obtained and carried out, which has characteristics of exploratory, diagnostic and predictive (Kothari, 2004). While, qualitative approach is also used to uncover trends in thought and opinions, and dive deeper into the problem (Ame and Baradyana, 2009). A mixed method approach is empirical research that involves the collections and analysis of both qualitative and Quantitative data.

Selection of choices according to this study was based to Cresswell, (2003) due to the facts that it contains all the research process in the research approach concerning this study.

3.3.2 Target Population and Sample Frame

Population means a group of items that samples were drawn from (Diamantopoulos, 2004). Also Bryman, (2008) "refers to the universe of units from which the sample is to be selected. The population for this study comprised all individuals who were the users or beneficiaries of the decentralized health services in Babati Town Council.

The targeted population for this study was the total number of about sixty five Babati Town Council health sector stakeholders. It included town health office management, health center head, heads of health services board/committees and health service beneficiaries. Sample frame is the specific set of units from which the sample is actually drawn (O'Sullivan and Rassel, 1989). The sample frame in this study was constituted health officers in their working stations, as well as health beneficiaries in the health centers and hospitals.

Selection of choices for justification according to this study was based on Bryman (2008) due to the facts that it is more scientific explained by the author and currently cited compared to the first one.

3.4 Sources and Methods of Data

3.4.1 Source of Data

Both secondary and primary data was collected to capture information needed for analysis. According to Mbogo (2012) primary data are information gathered directly

from experimental studies or respondents using research instruments. Secondary data was collected from different sources such as government offices and some published and unpublished hard and soft information sources. Furthermore, Primary data was obtained from the respondents such as health beneficiaries from Bonga health center and others from Babati (Mrara) town hospital. Also, from Town Health Office Management, Head of Health Center and Heads of Health Services Board/Committee who are key informants. Secondary data was obtained from the study like annual performance analysis, plan and report, policy and the like.

3.4.2 Data collection Methods

3.4.2.1 Interview Method

Is a method of data collection which involves presentation of oral-verbal stimuli and reply in terms of oral- verbal responses (Kothari, 2005),Similarly, Mbogo et al. (2012) defined interview as a data collection technique that involves oral questioning of respondents, either individually or as a group. In this study, interview guide will be used to collect data from the five key informants.

Selection of choices according to this study was based on Mbogo et al., (2012) due to the facts that explanations given to him can well understood by the readers easily due to the simple language used. Also the source is too current compared to first elaborations.

3.4.2.2 Survey Method

Survey method is the one that gathers data from a relatively large number of cases at a particular time (Kothari, 2004). A survey is basically a data collection instrument for carrying out study research, Pinsonneault and Kraemer (1993) defined a survey

as a means for gathering information about the characteristics, actions and opinions of a large cluster of people. In this study, questionnaires containing a set of both open and closed-ended questions were used to collect data from 60 health beneficiaries. Questionnaires are instruments of data collection that consists of predetermined and structured question given to the subject to respond in writing (Kumar, 2011).

A questionnaire is a formalized set of questions that help to obtain information from respondents. The main aim is to translate the researcher's information needs into a set of specific questions that respondents are willing and able to answer (Malhotra, 2004). Furthermore, questionnaires give a chance to respondent who cannot take part in the discussions. As Jackson-Plaatjies puts it: "We have found that the meeting times (duration) do not allow adequate time for input from the majority of attendees at these meetings. The main aim of the questionnaire is to give those participants who do not get a chance to speak (the opportunity) to put across their views and mainly their needs". Questionnaires were used because they are easy to administer and enable the researcher collect qualitative information within a short period of time. The questions were pre-coded in order to save time, cover a large number of respondents and minimize bias on the side of the researcher as well as on the respondents. Both closed and open-ended questionnaires were used to obtain qualitative information concerning administrative attitudes on community participation process and decentralized health service delivery. Every question in a questionnaire was either asks for nominal or ordinal data that enable the researcher to simplify data coding and entry. However, the developed questionnaires were pre-tested before actual data collection in order to determine its suitability and make the

necessary changes so as to collect reliable data. The questionnaires were included respondents; the beneficiaries (especially the patients) who in this study regarded as health beneficiaries from the Babati (Mrara) town hospital and Bonga health center.

Selection of choices according to this study was based on Kumar (2011) due to the facts that the explanation given is easily understood by the readers and including simple language which is more elaborated; also the source is too current compared to others.

3.4.2.3 Documentary Review

This is the review of the information gathered from other previous studies, such as published material, and information from internal sources such as raw data and unpublished summaries (Best and Khan, 1998; Mbogo et al., 2012). Review of documents is a process of reading with or associated with issues related to what the researcher is studying (Borg and Gall, 1996).

In this study secondary data was collected through various document analyses which included data of the impact of administrative attitudes on community participation in the delivery of decentralized Health services from Health service offices provided by key informants such as Babati Town Health Office Managers.

Selection of choices according to this study was based on Best and Khan; Mbogo et al., due to the reasons that it is well elaborated relating to the study. Also, the source is currently cited.

3.5 Sampling technique and Sample Size

3.5.1 Sampling technique

According to Kombo and Tromp (2006) sampling technique is the plan that specifies how the respondents of the research are going to be selected. It is the process of obtaining information about entire population by examining a part of it; (Kothari, 2004).The sampling techniques to be applied in this study was both probability and non-probability sampling in order to obtain respondents from the target population for the study.

In probability sampling, each element in the population is given an equal and independent chance of selection (Kumar, 2011). In that, simple random sampling was used to select about sixty health beneficiaries. Simple random sampling ensures the law of statistical regularity which states that if on an average the sample chosen is a random one, the sample will have the same composition and characteristics as the universe (Kothari, 2004). In non-probability sampling the items of the sample is selected deliberately by the researcher (Kothari, 2004). The technique of non-probability sampling that was used in this study was purposive sampling to obtain specific data from town health office management, health center head, and heads of health services board/committee. Purposive sampling enables a researcher to pick respondents who are useful in data collection for research finding (Kothari, 2004).

Selection of choices according to this study was mostly based to (Kumar, 2011) because it shows specifically that each element in the population is given an equal and independent chance of selection. Both simple random and purposive sampling was used to obtain data in the field as probability and non probability sampling techniques according to this study.

3.5.2 Sample Size

According to Kothari (2011), sample size refers to the number of items to be selected from the universe to constitute a sample. Sample size refers to the number of elements to be included in the study (Malhotra, 1996). Sample size for this study will be 65 respondents in Babati Town council. Data will be collected from 60 health service customers (30 health customers from Babati (Mrara) town hospital and 30 health service customers from Bonga health center), 1 head of health center, 2 heads of health service board/committees and 2 officers from town health office management. Sample size is reflecting to Bailey (1998) a minimum 30 cases are enough for statistical analysis.

Selection of choices according to this study is based to the first explanation by Kothari (2011) due to the scientific words used to constitute meaning of sample size generally.

Table 1: Distribution of Sample size

S/N	Unit	Number of Respondents
1	Town Health Office Managers	2
2	Head of Health Center	1
3	Heads of health service Board/Committee	2
4	Health service beneficiaries	60
	Total	**65**

Source: Researcher's Own Construction

3.6 Data Analysis

Marshall and Rossman (1999) describe data analysis as the process of bringing order, structure and meaning to the mass of collected data. Broadly speaking it is the

activity of making sense of, interpreting and theorizing data that signifies a search for general statements among categories of data (Schwandt, 2007).

The obtained data was edited so as to detect errors and to ensure that the data are accurate, consistence with other facts and uniformly entered. The collected raw data was also coded before being entered into the computer so that to put responses into limited number of appropriately categories for efficient analysis. The data was collected and analyzed and presented so as to answer research questions and objectives of the study from which conclusion and recommendations were drawn. Qualitative data was analyzed by using descriptive statistical analysis. The use of computer was employed Statistical Package for Social Sciences and Micro Soft Excel. Data was presented by using tables, figure, percentages and frequencies. These methods of data analysis are simple and can be easily understood by majority. The data was also interpreted in accordance with the research objectives.

The selection of my choice according to this study is based on Schwandt (2007) because He has tries to explain data analysis in detail.

3.7 Reliability and Validity of Data

3.7.1 Reliability of Data

Reliability refers to the extent to which data collection techniques and analysis was yield consistent findings (Sounders, 2009). Reliability is the instrument likely to give consistent results across time, place, and similar instrument, irrespective to who is using it (Omar, 2011 and Torrington, 2002) and highly reliable is valueless unless the instrument has high validity. Before conducting the study, the instrument was trial tested to fifteen (15) respondents and who was not be involved in the study.

Data collected were checked whilst still in the field to ensure that all questions are answered. Results from tryout exercise were enabled the modifications of instrument in order to make them appropriate for collecting valid and reliable data.

Selection of choices according to this study is based on Sounders (2009) because his explanation is very simple and clear.

3.7.2 Validity of Data

According to Omar, 2011, Validity is the instrument capable of measuring what is supposed to measure accurately, effectively and efficiently. Validity is concerned with whether the results are really about what they appear to be about (Saunders, *et. al.,* 2009). Moreover, validity is concerned with the idea that the research design fully addresses the research questions and objectives researcher is trying to answer and achieve respectively. Similarly, validity means measuring the right things (Sounders, 2009). Hence, the study was carried out in such a way that there is consistency between theory and practice. This also was achieved through careful design of directions for measurements with no variation from group to group.

This will be achieved through setting standards on constructing questionnaires and interview questions which were related to the researcher's objectives and questions. Selection of choice according to this study is based on Sounders (2009) because his explanation is simple and clear.

3.8 Ethical Consideration

Ethical consideration is critically important in any research. It is based with describing and prescribing moral requirements and behaviors, which suggests that there are acceptable and unacceptable ways of behaving that serve as a function of

philosophical principles (Minkes, Small, &Chatterjee, 1999). With this regard, this study was sensitive with ethical grounds in all steps of the study. Ethical implication has been observed in the preparation of this proposal. The researcher was adhered to ethical issues by being honest throughout the research process, from the preparation of the proposal writing, data collection, data analysis and data interpretation. The information that was provided by the respondents were handled with confidence and was for the purpose intended by this research, this research which was for the partial fulfillment of Masters Degree in Public Administration (MPA). To ensure this, the University was provided identification letter that was used by the researcher to identify him/her to the respondents during data collection. Furthermore, the researcher was responsible for any inconvenient that occurred to the respondent caused by being involved.

To sum up, the researcher was asked the informed consent from the respondents to willingly participate and provide information. The researcher was observed the right of the respondents to privacy and confidentiality of the information that was provided. In ensuring research principles, the researcher ensured confidentiality on personal identities of the respondents and those associated with the information that was provided.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents and argues the findings of the study. For the purpose of demonstrating the relationship among the various variables, the data are presented in the form of tables, frequencies and percentages where applicable. The results are presented in tables according to the questions. The research also tried to fulfill all the objectives of the study.

4.2 Demographic Characteristics

The study sought to establish general information about the health service respondents and their fitness in providing data required by this study. The findings were discussed below.

Table 2 gives information on the composition of the health beneficiary respondents in terms of sex, age, marital status and level of education. Summarized health beneficiary respondents information on sex, age, marital status and level of education might give the researcher a clue about health beneficiary respondents understanding of the impact of administrative attitudes on community participation in the delivery of decentralized health services in Tanzania. In addition, health beneficiary respondents represent appropriate gender mix which tells both sex participated and both served in health center and hospital for primary health care.

Table 2: Demographic Characteristics of Health Beneficiary Respondents (N=60

		Respondents (%)	
Variable	**Descriptions**	**Frequency**	**Percent**
Sex	Male	23	38.3
	Female	37	61.7
Age	<20	4	6.7
	20-30	30	50.0
	30-40	14	23.3
	>40	12	20.0
Marital status	Married	42	70.0
	Single	11	18.3
	Divorced/separated	4	6.7
	Widow/widower	3	5.0
Education Level	Standard VII	41	68.3
	Form IV	10	16.7
	Diploma	9	15.0

Source: Field Data Survey, (2018)

In addition to the secondary data, the researcher was collected primary data through interview and questionnaires. The data were collected to supplement primary source by giving additional information of administrative attitudes on community participation in the delivery of decentralized health services in Babati Town Council.

The study targeted 60 health beneficiary respondents from which 60 filled in and returned the questionnaires making a response rate of 100.0%. This observation rate was excellent and representative and conforms to Mugenda and Mugenda (1999) stipulation that a response rate of 50% is adequate for analysis and reporting. A rate of 60% is good quality and a response rate of 70% and above is excellent.

4.2.1 Sex of Respondents

The sex of respondents sought to know and to understand the composition of community in terms of sex. The findings in Table 2 on sex of health beneficiary respondents reveal that 61.7% of health beneficiary respondents were female higher than 38.3% of male health beneficiary respondents, for both Babati Town hospital and that of Bonga Health Center. Discussion of the results show that female health customer respondents exceed male health respondents, this implies that females have traditionally health care responsibilities in the family.

On the basis of a wide-ranging American survey carried out in the 1960s, 'Responsibility for knowing about health seems to be part of the woman's role in the family' (Wade and Schramm, 1969). Women are thus by tradition and upbringing expected to take the role of gatekeepers and custodians of the health of others and act as the primary brokers of health care within families (Umberson, 1992; Norcross *et al*., 1996; Richardson, 2010). Accordingly, the disparities in favour of women in the engagement in health-related information have also been suggested to have their deepest roots in culturally ascribed gender characteristics and behaviour (Urquhart *et al.*, 2010).

4.2.2 Age of Respondents

The respondents' age sought to know and to understand the composition of community in terms of age distribution. The finding in Table 2 shows that, about 50% of health customer respondents were in the age group ranging between 20 and 30 years, while 6.7% were below 20 years. On the other hand, 23% of them were aged between 30 and 40 years, 20% were above 40 years. In general, the results show that the majority of health beneficiary respondents were in the age between 20

and 50 years could therefore be expected to attend more as health customer respondents because they range within the most responsible age group in the families for taking health care of others, most of this group were women with small children.

Discussion of the results show that older people have, for instance, been found to be people with higher health consciousness and awareness (Macias and McMillan, 2008; Manafo and Wong, 2012); people with greater sense of responsibility for their own health (Gough and Connor, 2006; Tseng and Lin, 2008; Richardson, 2010); and people who, quite naturally, are more concerned about their health status (Norman, 1985; Leigh and Fries, 1992; Stoller and Pollow, 1994). However, despite these age-related influences on peoples' health information behaviour, the mean scores of females are consistently higher than that of males by approximately the same differences in every single age group.

4.2.3 Marital Status

The study sought to know and to understand the composition of community in terms of marital status. The finding in Table 2 shows that, about 70% of health customer respondents were married, while 18.3% were single. On the other hand, 6.7% of them were divorced or separated, 5% were widows or widowers. The study is supported by Batwel (2008), in a study conducted in Makete District, Tanzania. It was found that the majority (65.8%) of the respondents were married. These findings reflect a high marriage rate which is a common phenomenon in most of rural areas in Tanzania. This is possibly due to social responsibilities that require cooperative implementation by husbands and wives. In general, the results show that the majority of health customer respondents were married could therefore be

expected to attend more as health beneficiary respondents because they range within the most responsible group in the families for taking health care of their family members.

4.2.4 Education Level

The level of education determines one's reasoning capacity and conceptual ability. Health beneficiary respondents were asked on education level attained. The result in Table 2 shows that the majority (73.3%) of the respondents had completed Standard VII. This depicts the extent of implementation of the Universal Primary Education (UPE) programme and the Primary Education Development Plan (PEDP) which both insist on the rights of every child to attain free Primary School education (TDHS, 2004). The UPE and PEDP commenced in 1975 and 2006, respectively.

These results conform to those reported by Nkonjera and Batwel (2008) in Makete and Mbeya Districts, respectively for the same reason that is implementation of UPE Programme and PEDP. Besides, by acquiring that level of education by the majority of respondents, at least standard VII which is primary school education it shows that data provided by health customer respondents is reliable in giving proper information concerning delivery of decentralized health services.

Moreover, discussion of findings show that Education contributes to human capital by developing a range of skills and traits, such as cognitive skills, problem solving ability, learned effectiveness, and personal control (Mirowsky, 2005). These different forms of human assets may all intervenes the relationship between education and health. Educational achievement matters for health; past studies have shown that education levels are linked with health through health knowledge and

behaviors, literacy levels, employment status, insurance status as well as a variety of other social and psychological factors.

Those with higher educational attainment also tend to have higher health literacy levels, which enable them to better access, understand, and communicate actionable health information. While acknowledging the task that genetic traits, demographic factors and socioeconomic status have on health outcomes, we frame our study within the persistent association between educational attainment and health because of the influence of education level on accessing and understanding health information (Mirowsky, 2005). Therefore, there is a strong association between low reading skills and health outcomes which is thought to be primarily due to a general lack of knowledge about health and a lack of understanding about health services.

4.3 The Impact of Administrative Beliefs on the community's Provision of Labor and Materials in the Health Facilities in Tanzania

Objective one was designed to identify the impact of administrative beliefs on the community's provision of labor and materials in the health facilities. The section covers the following sub sections: available health facilities in the study area, community's provision of labor for health facilities and provision of materials in the health facilities. Others include administrative beliefs on the community's provision of labor and materials and the impact of administrative beliefs on provision of labor and materials in the health facilities.

4.3.1 Available Health Facilities in the Study Area

A health facility is generally, any location where healthcare is provided. Health facilities range from small clinics and doctor's offices to urgent care centers and

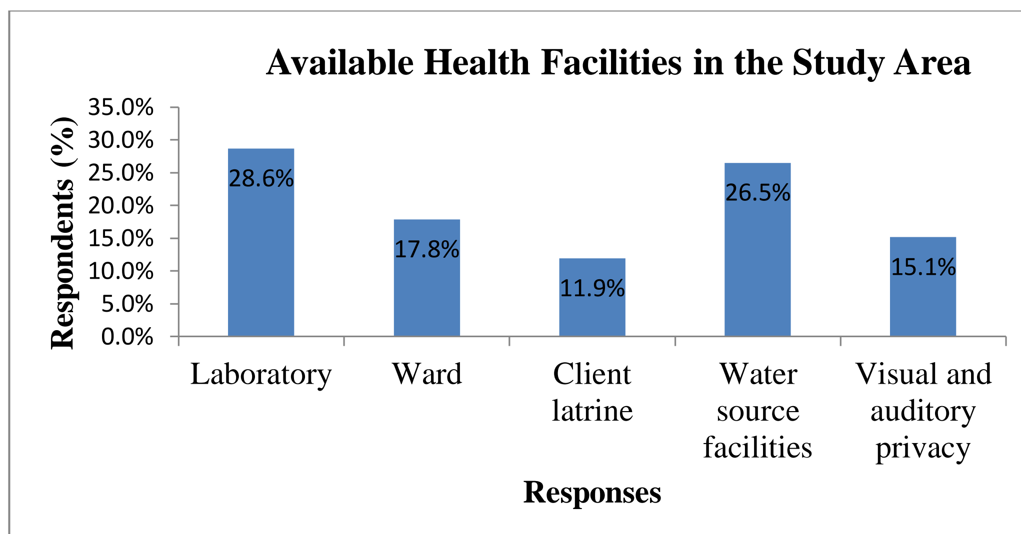
large hospitals with elaborate emergency rooms and trauma centers (Ahmadi-Javid, *et al*., 2017). The study was interested to assess the available health facilities in the study area, questions were presented for the beneficiaries of the health center and hospital. The findings in Figure 2 revealed that, 28.6% of health beneficiary respondents said laboratory is the most available health facility found in the study area, while 26.5% of health beneficiary respondents said there is water source facility. The findings further showed that, 11.9% of them indicated the availability of client latrine, from which one can conclude that the health center and hospital had inadequate health facilities such as ambulances, permanent electricity power and theater rooms that cannot sustain the demands of the dwellers of the community. During the interview one of the key informants in Health center stated that:

> *"We have been admitting patients to Babati Town hospital because of unavailable theater rooms, ambulances and permanent electricity power"*. (Quote: From one of the Key Informants in Bonga Health Centre, 2018).

This statement shows that unavailable of crucial health facilities such as theater rooms in rural areas have been affecting the delivery of decentralized health services. The study findings are supported by Blunden *et al*. (2015), in a study on infrastructural challenges to better health in maternity facilities in rural Kenya. It was reported that lack of basic infrastructures including quality water and electricity supply has been associated with poor quality health services in rural Kenya. Only 58 % of all hospitals in the country have an all-year supply of water, while one-quarter have uninterrupted electricity supply KNBS and ICF Macro, 2010).

In fact, the number and quality of health facilities in a country or region is one common measure of that area's prosperity and quality of life (Ahmadi-Javid, *et al.*, 2017). Therefore, there is a need to ensure better equity in access to healthcare facilities for improvement of the delivery of decentralized health services.

Figure 2: Available Health Facilities in the Study Area



Source: Field Data Survey (2018)

4.3.2 Community's Provision of Labor in the Health Facilities

Health beneficiary respondents were asked about their community's provision of labor in the health facilities and their responses are presented in Table 3. The findings revealed that, 40.0% of health beneficiary respondents participated in the community's provision of labor on the availability of health facilities through suggestion and advice, while 33.3% of the health beneficiary respondents provided physical facilities including participation in construction of ward and laboratory facilities. This implies that health beneficiaries participated in provision of labor for the health facilities. However, 26.7% of them have not participated in the community's provision of labor for health facilities. This is because some of health

customers were not aware of decentralized health services but many health customers were aware of this for the improving health services.

Table 3: Community's Provision of Labor to Health Facilities (N=60)

Descriptions	Frequency	Percent
Not providing labor	16	26.7
Physical facilities	20	33.3
Suggestion and advice	24	40.0
Total	**60**	**100.0**

Source: Field Data Survey (2018)

4.3.3 Community's Provision of Materials in the Health Facilities

Health beneficiaries were asked about their provision of materials in the health facilities. The findings in Table 4 revealed that, 48.3% of the health beneficiary respondents provided building materials including cements, bricks and iron sheets. Besides, 30.0% health beneficiary respondents contributed financial support. On the other hand, 21.7% of them did not provide materials in the health facilities. The study showed that most of health beneficiaries understand the importance of providing materials to health facilities in the study area. During the interview one of the key informants stated that:

> *"It is true that community members have been involving in provision of materials including cements, bricks and iron sheets as well as financial support in improving health facilities*". (Quote: From one of the Key Informants in Bonga Town Hospital, 2018).

This statement indicates that the community understands the importance of participating and contributing materials for availability of health facilities. This

signifies the need to improve administrative beliefs toward the community in the delivery of decentralized health services for the quality health services.

Table 4: Community's Provision of Materials in Health Facilities (N=60)

Descriptions	Frequency	Percent
Not providing materials	13	21.7
Building materials	29	48.3
Financial Contribution	18	30.0
Total	**60**	**100.0**

Source: Field Data Survey (2018)

4.3.4 Health Beneficiary toward Administrative Beliefs on Provision of Labor and Materials

The study was interested to understand the opinions of health beneficiaries toward administrative beliefs on provision of labor and materials. The findings in Table 5 revealed that, 41.7% of health beneficiary respondents indicated that health administrators believed communities have no competence concerning provision of labor and materials in the health facilities. While 25.0% of health beneficiary respondents confirmed that health administrators believed that communities lack skills on provision of labor and materials in the health facilities. This implies that community participation in the delivery of decentralized health services was affected mostly by administrative beliefs on provision of labor and materials. During the interview one of the key informants stated that:

"We do not trust community members' contribution in construction of health facilities, because many of them lack knowledge, skills and expertise on management on the delivery of decentralized health

service". (Quote: From one of the Key Informants in Bonga Health Centre, 2018).

This statement indicates that health administrators have negative beliefs on community participation on provision of labor and materials of health facilities. This has been affecting community participation in decentralized health services delivery. Therefore, there is a need to improve health administrative beliefs so as to improve the state of lower-tier health facilities serving communities.

The findings on opinions of health customers toward administrative beliefs on provision of labor and materials are given in Table 5.

Table 5: Health Customers toward Administrative Beliefs on Provision of Labor and Materials (N=60)

Descriptions	Frequency	Percent
Lacking competence	25	41.7
lacking expertise	13	21.7
lacking skills	15	25.0
Lacking time for meaningful participation	7	11.7
Total	**60**	**100.0**

Source: Field Data Survey (2018)

4.3.5 Impacts of Administrative Beliefs on Community's Provision of Labor and Materials on Availability of Health Facilities

Health beneficiaries were asked about impact of administrative beliefs on community's provision of labor and materials in health facilities. The findings in Table 6 revealed that, 46.7% of health beneficiary respondents said inadequacy of

information and feedback as one of the impacts of administrative beliefs on community's provision of labor and materials in health facilities.

More so, 31.7% of health beneficiary respondents indicated implementing un-prioritized health facilities as the impact of administrative beliefs on provision of labor and materials in health facilities. The remaining of them about 16.7% giving the impact to be lack of transparency on resource allocation, whereas 5.0% were mentioned the impact to be minimal involvement of community, respectively. This implies that community participation in the delivery of decentralized health services has been affected mostly by administrative beliefs.

Table 6: Impacts of Administrative Beliefs on Community's Provision of Labor and Materials in Health Facilities (N=60)

Descriptions	Frequency	Percent
Implementing un-prioritized health facilities	19	31.7
In adequacy of information and feedback	28	46.7
Minimal involvement of community	3	5.0
Lack of transparency on resource allocation	10	16.7
Total	**60**	**100.0**

Source: Field Data Survey (2018)

4.4 The Effect of administrative Perception on the Community's Demand for Health Needs and Preferences in Human Resources, Adequate Drugs and Funds

Objective two was designed to examine the effect of administrative perception on the community's demand for health needs and preferences in human resources, adequate drugs and funds in Tanzania. The section covers the following sub sections; health needs followed by health beneficiaries, satisfaction of health needs, adequacy of health personnel and drugs, methods used by health beneficiaries to ensure availability of health personnel and drugs. Others include participation of health beneficiaries in selection of health needs, participation of health beneficiaries in allocation and uses of funds. Finally is the effect of administrative perception on the community's demand for health needs and preferences.

4.4.1 Health Needs and Preferences Followed by Health Beneficiaries

The results in Figure 3 show the kind of health needs followed by health customers. The findings revealed that, 28.2% of health beneficiary respondents went to health centre and hospital for clinic purposes, while 27.0% of health beneficiary respondents went to health centre and hospital for pregnancy follow-up. Besides, 22.1% of them said they visited the health center and hospital for family planning services, while 22.7% of health beneficiary respondents visited health center and hospital for immunization. This implies that the health center and hospital provide different types of health needs to community members as confirmed by one of the key informants in Bonga health center:

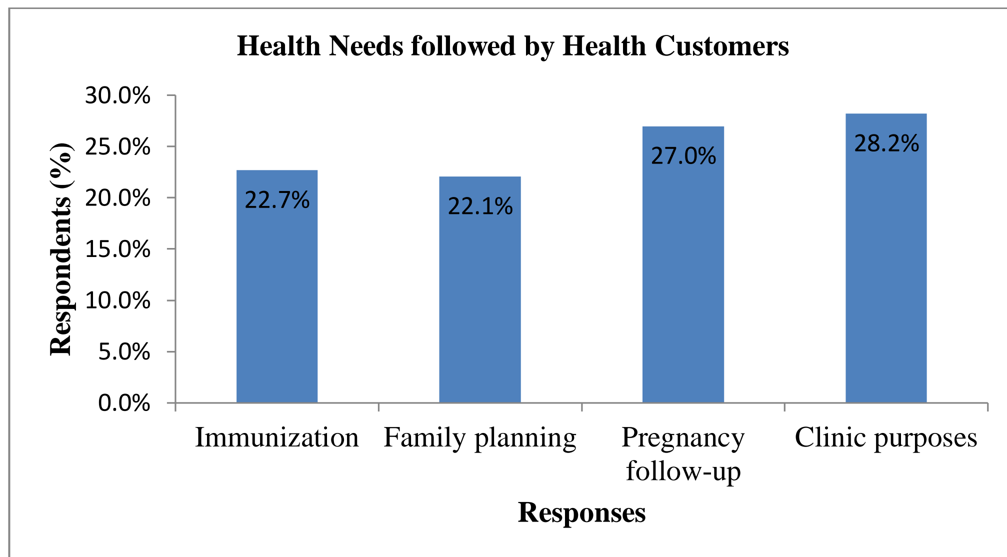
"People come to our health center for different purposes; some of them come for immunization, family planning and others for clinic

> *purposes because these are common health needs that are preferred by the community".* (Quote: From one of the Key Informants in Bonga Health Centre, 2018).

Purposively, the discussion of the results corroborate that: this perspective of health needs and preferences comes from the field of public health in which preventive health services are conceptualized at three levels: primary, secondary, and tertiary prevention (National Academy Press; 2003), primary prevention includes immunization, healthy lifestyles, and working and living in risk-free environments. Primary prevention seeks to prevent disease or delay its onset. Examples of primary prevention include immunizations against infectious disease; smoking prevention or cessation; and promotion of regular exercise, weight control, and a balanced diet.

More so, secondary prevention includes the range of interventions that can reduce the impact of disease morbidity once it occurs and slow its progression. With the increasing burden of chronic diseases, much of the health care provided is directed at secondary prevention. Tertiary prevention is directed at rehabilitation for disabilities resulting from disease and injury. The goal of tertiary prevention is to return individuals to the highest state of functioning (physical, mental, and social) possible (National Academy Press; 2003). The public health framework expands the structure, process, and outcome conceptual model by identifying the role and value of health services at three stages: prior to onset of disease, disease management, and disease recovery and rehabilitation.

Figure 3: Health Needs and Preferences Followed by Health Customers (N=60)

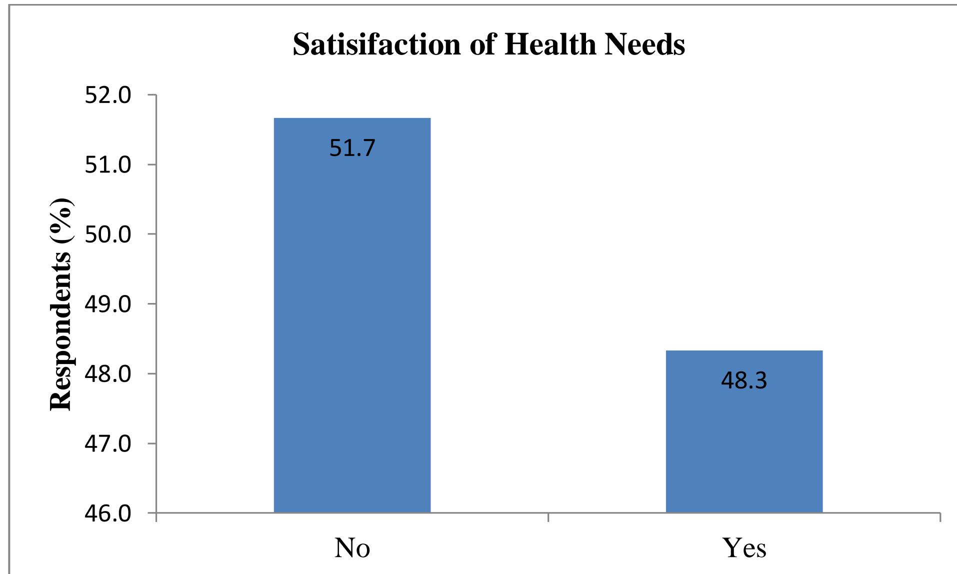


Source: Field Data Survey (2018)

4.4.2 Satisfaction of Health Needs or Services

The study was interested to assess health beneficiary satisfaction of health needs. The findings in Figure 4 show that, 51.7% of health beneficiary respondents were satisfied with health services or needs, while 48.3% of health beneficiary respondents were not satisfied with health services or needs. This implies that half of health customers were not satisfied with the needed health needs or services. According to McCormick *et al*. (2002), the importance of studying treatment satisfaction is well documented: numerous health organizations have implemented a measurement of patient satisfaction in projects designed to improve quality of health services. Quality of health services is evaluated by three equally important measures: structure, process and outcomes. Besides, Finkel (1997) concluded that, treatment satisfaction is included in the process component and is used as an important indicator of quality of health service delivery.

Figure 4: Satisfaction of Health Needs/Services



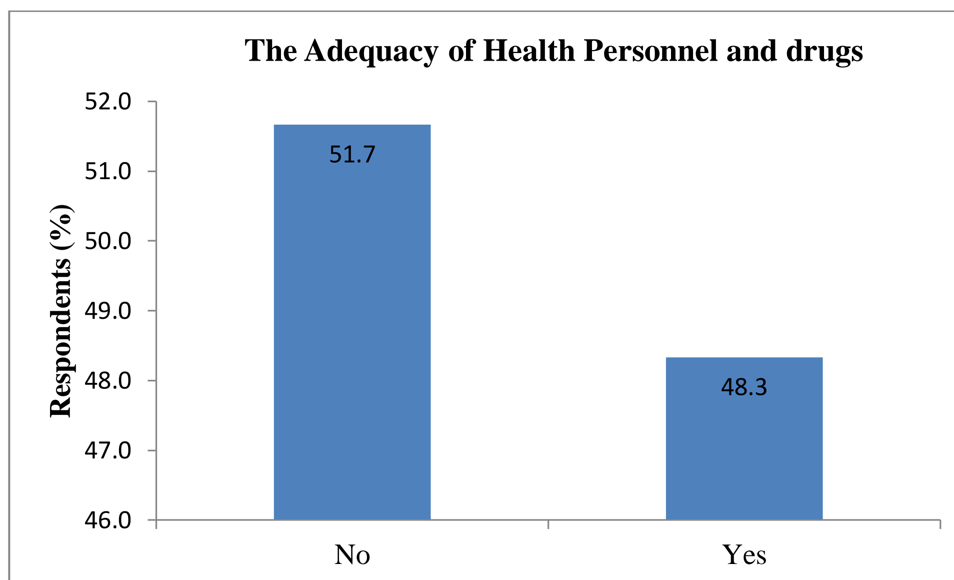
Source: Field Data Survey (2018)

4.4.3 Adequacy of Health Personnel and drugs

Human resources and drugs are key performance drivers within public health. Health beneficiary respondents of the health center and hospital were asked whether there were adequate health personnel and drugs. The findings in Figure 5 showed that, 51.7% of health beneficiary respondents said there were inadequate health personnel and drugs, while 48.3% of health beneficiary respondents said there were adequate health personnel and drugs. This implies that community is not satisfactory with the delivery of decentralized health services due to inadequacy of health personnel and drugs.

The findings on adequacy of health personnel and drugs are presented in Figure 5.

Figure 5: Adequacy of Health Personnel and Drugs



Source: Field Data Survey (2018)

Nevertheless, on assessing adequacy of health personnel in Babati Town Hospital one of the key informants said that:

> *"We attend 600 health beneficiaries per day but we cannot accommodate all of them. This is because of inadequacy of health personnel. There are only 30 medical doctors, 80 nurses,* 3 *pharmacists".* (Quote: From one of the Key Informants in Babati Town Hospital, 2018)**.**

This statement indicates that inadequacy of nurses, pharmacists and doctors have been hindering delivery of decentralized health services. The International Pharmacy Federation (FIP) provided further evidence of the need for a Human Resources focus in Supply Chain Management through their Global Workforce Report in 2012. In

that report, it makes a link between a lack of pharmacy personnel and inequalities in access to medicines. For example in Sub-Saharan Africa, on average less than one pharmacist was observed for caring 10,000 populations (FIP, 2012). Therefore, the government and other health stakeholders should unite so as to overcome these shortages and increase the availability of health personnel and drugs especially in the rural health services.

4.4.4 Methods Used by Health Customers to Ensure Availability of Health Personnel and Drugs

The study was interested to assess methods used by health customers to ensure availability of health personnel and drugs. The results in Table 7 show that, 58.3% of the health beneficiary respondents used a method of consulting community leaders such as ward councilors who represent them in town council, while 26.7% of them reported used a method of consulting health committee, fewer 15.0% of the health beneficiary respondents used a method of writing proposals in village meetings. This implies that community was aware and used different methods to ensure availability of health personnel and drugs apart from health committee and boards which act as representative to the community to the health affairs. This includes such methods of consulting community leaders and by writing proposal to central government through village meetings.

Table 7: Methods Used by Health Beneficiaries to Ensure Availability of Health Personnel and Drugs (N=60)

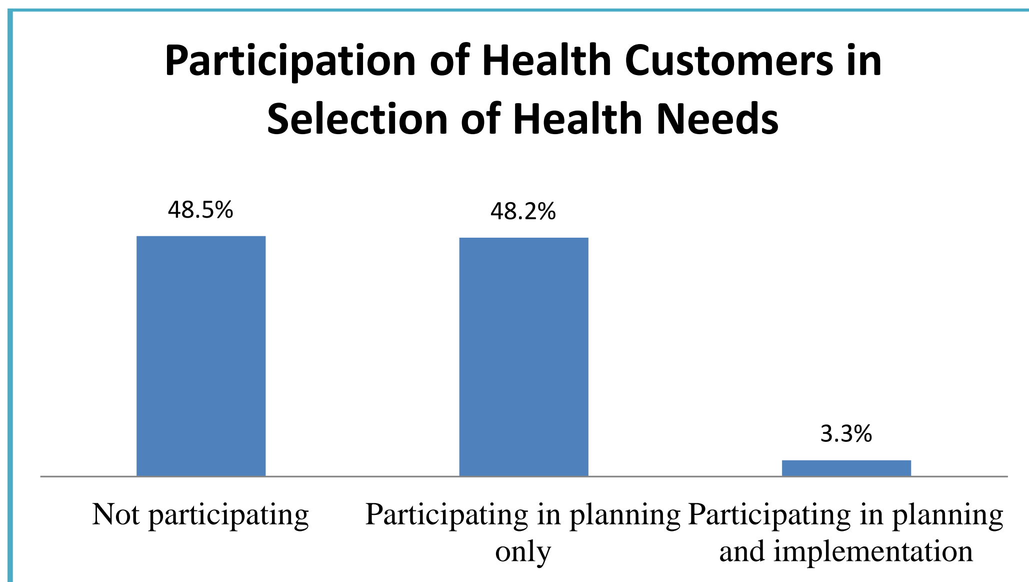
Descriptions	Frequency	Percent
Consulting community leaders	35	58.3
Consulting health committee/boards	16	26.7
Writing proposals in village meetings	9	15.0
Total	**60**	**100.0**

Source: Field Data Survey (2018)

4.4.5 Participation of Health Customers in Selection of Health Needs

Health beneficiary respondents were asked about their participation in the selection of health needs and their responses are also presented in Figure 6. Out of 60 health beneficiary respondents participated in filling the survey questionnaire, 48.2% of health beneficiary respondents were participated in planning only in the selection of health needs. This shows that most of health customers participate in a planning stage and not in other stage such as implementation and evaluation. This is because health providers perceive that community members have no skills to participate in evaluation of health programs.

Figure 6: Participation of Health Customers in Selection of Health Needs



Source: **Field Data Survey (2018)**

The findings further revealed that, 48.5% of health beneficiary respondents did not participate in selection of health needs. Only 3.3% of health beneficiary respondents participated in both planning and implementation. The study showed that community participated much in planning only which is passive kind of participation. This implies that the level of community participation in implementation and evaluation during the selection of health needs is minimal. The study is supplemented by one of the key informants in Bonga Health Centre who said:

> *"We have been involving communities during planning in selection of health needs such as drugs and health personnel, but not in implementation and evaluation because most of them are not educated".* (Quote: From one of the Key Informants in Bonga Health Centre, 2018).

This statement indicates that administrative perception towards the community in selection of health needs is negative because they perceive health beneficiaries as ignorant that cannot participate in implementation and evaluation. This results to poor delivery of decentralized health services. Therefore, for active community participation in delivery of decentralized health services there must be entire involvement starting from planning, implementation and evaluation so as to ensure availability of human resources and drugs.

4.4.6 Participation of Health Beneficiaries in Allocation and Uses of Funds

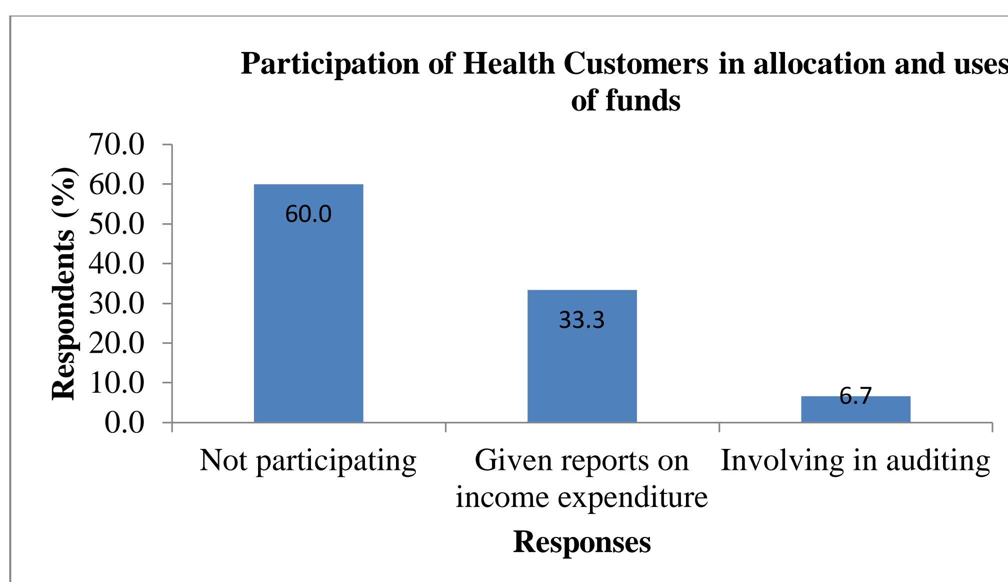
A key barrier to improved quality and access to delivery of decentralized health services is the lack of effectiveness and efficiency in health financing (TSPA, 2014). Health beneficiaries were asked about their participation in the allocation and uses of funds. The results in figure 7 show that, 60.0% of health beneficiary respondents did not participate in allocation and uses of funds on the availability of health needs including human resources and adequate drugs. The study showed that, the majority of community members did not participate in allocation of funds for health needs as confirmed by of the key informants in Babati Town Hospital.

> *"Financial issues need accountants and treasuries. Therefore, we exclude community members when it comes to allocation of funds, but we have been putting reports on notice boards concerning income and expenditures".* (Quote: From one of the Key Informants in Bonga Health Centre, 2018).

Furthermore, 33.3% of health beneficiary respondents said found reports on notice boards concerning income and expenditures. Fewer 6.7% of health beneficiary

respondents participated through committee leaders who involve in auditing. These imply that health beneficiaries were not fully participated in the allocation and uses of funds and the delivery of decentralized health services. This has been resulting to poor delivery of decentralized health services. Therefore, there is a need to involve community members in allocation of funds so as to increase transparency and accountability. The results on participation of health beneficiaries in allocation and uses of funds are presented in Figure 7.

Figure 7: Participation of Health Customers in Allocation and Uses of Funds



Source: Field Data Survey (2018)

4.4.7 Effect of Perception on the Demand for Health Needs and Preferences

Health beneficiary respondents were asked about effect of perception on the demand for health needs and preferences. The results in Table 8 revealed that, 55.0% of health beneficiary respondents said misuse of public resources is one of the effects of perception on the demand for health needs and preferences. In addition, 33.3% of health beneficiary respondents said selection of un-prioritized health needs as the

effect of perception, while 11.7% of them reported failure to meet local needs is the effect of perception on the demand for health needs and preferences. This implies that administrative perception have effect towards community participation in primary health care and in the delivery of decentralized health services.

Table 8: Effects of Perception on the Demand for Health Needs and Preferences

Descriptions	Frequency	Percent
Selection of un-prioritized health needs	20	33.3
Misuse of public resources	33	55.0
Failure to meet local needs	7	11.7
Total	**60**	**100.0**

Source: Field Data Survey (2018)

4.5 Influence of Administrative Behavior on the Community's Selection of Technology of Medical Equipments in Tanzania

Objective three was designed to analyze the influence of administrative behavior on the community's selection of technology of medical equipments in Tanzania. This section covers the following sub sections; available medical equipments, participation of health beneficiaries on the selection of technology**,** health beneficiary's opinions on how administrative behavior affects selection of technology and health beneficiary's suggestions on the selection of technology.

4.5.1 Available Medical Equipments

In order to assess the availability of the medical equipments in the study area, questions were presented for the beneficiaries of the health center and hospital. The results in Table 9 revealed that, 100.0% of health customer respondents confirmed the availability of Thermometers, followed by 93.3% of health beneficiary

respondents confirmed the availability of BP apparatus while, 81.7% of them indicated the availability of Stethoscope. This proves that the mentioned medical equipments were most used and preferred by health beneficiaries. A similar case is reported by FIP (2012) in a global workforce report conducted in Tanzania. It was reported that, an adult scale, a child scale, an infant scale, a thermometer, a stethoscope, a blood pressure apparatus, and a light source comprise the basic equipments domain for assessing general service readiness.

However, 61.7% of health beneficiary respondents indicated the absence of computers in the targeted health centre and hospital. This shows that there is scarcity of medical equipments such as computers, Ultra sound and MRI machines, PET and CT scanners, x-ray machines as well as infusion pumps and LASIK surgical machines as confirmed by one of key informants:

> *"There is a scarcity of most important medical equipments, for instance, we have only 3 computers in this hospital and we do not have Ultra sound and MRI machines, PET and CT scanners, x-ray machines, infusion pumps and LASIK surgical machines. This has been forcing us to refer the patients to Regional hospital".* (Quote: From one of the Key Informants in Babati Town Hospital, 2018).

This calls for more interventions to increase computers in health services operations and programs to strengthen the delivery decentralized health services.

Table 9: Available Medical Equipments

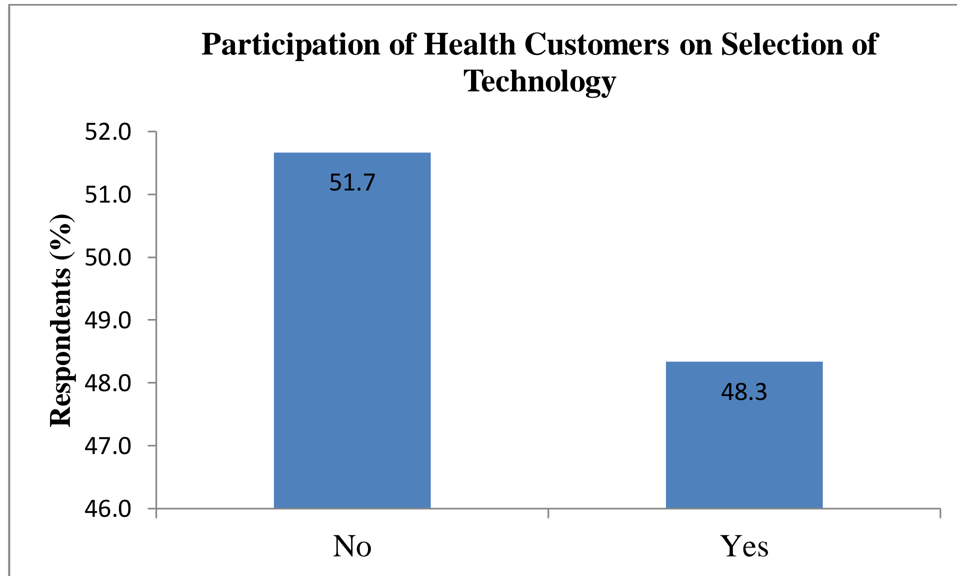
	Respondents (%)				
Variables	**Thermometer**	**BP apparatus**	**Stethoscope**	**Adults scale**	**Computers**
No	0.00	6.7	18.3	21.7	61.7
Yes	100.0	93.3	81.7	78.3	38.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: Field Data Survey (2018)

4.5.2 Participation of Health Customers on the Selection of Technology

The study was interested to understand participation of health beneficiaries on the selection of technology and their response are presented in Figure 8. Out of 60 health beneficiary respondents participated in filling the survey questionnaires. About 51.7% of health beneficiary respondents did not participate on the selection of technology. Besides, (48.3%) of health customer respondents were participated on the selection of technology. This implies that community participation on the selection of technology is poor. Therefore, there is a need to increase community participation on the selection of technology including medical equipments.

Figure 8: Participation of Health Customers in Selection of Technology



Source: Field Data Survey (2018)

4.5.3 Health beneficiary's Opinions on How Administrative Behavior Affects Selection of Technology of Medical Equipments

Health beneficiary's opinions on how administrative behavior affects selection of technology are presented in Table 10. Most of the health beneficiary respondents 46.7% indicated that misuse of public resources is the effect of administrative behavior on selection of technology on the availability of medical equipments. This implies that misuse of public resources including corruption hinders health beneficiary to access health services. Hence failure of delivery decentralized health services. This is supported by Fonn et al. (2015) in a study on corruption in the South African health sector. It was found that, misuse of public resources has a negative effect on patient care and the morale of healthcare workers. The majority of the print media reports on fraud concerned the community health sector was about 63% and involved provincial health departments 45%. Characteristics and complexity of the public health sector may increase its vulnerability to misuse of

public resources, but the private-public binary constitutes a false dichotomy as corruption often involves agents from both sectors. Despite the lack of global validated indicators to measure corruption, our findings suggest that corruption is a problem in the South African healthcare sector. Misuse of public resources including corruption is influenced by adverse agent selection, lack of mechanisms to detect corruption and a failure to sanction those involved in corrupt activities.

More so, 31.7% of health beneficiary respondents indicated that the needs of local people are not satisfied. The remaining of them about 18.3% and 3.3% was mentioned the administrative behavior results to improper technology and provision of un-demanded equipments, respectively. This implies that selection of technology on the availability of medical equipments have been affected mostly by the behaviors of administrators.

Table 10: Health Beneficiary's Opinions on How Administrative Behaviors Affects Selection of Technology

Descriptions	Frequency	Percent
The use of improper technology	11	18.3
Provision of un demanded equipments	2	3.3
Misuse of public resources	28	46.7
Needs of local people not satisfied	19	31.7
Total	**60**	**100.0**

Source: Field Data Survey (2018)

4.5.4 Health Beneficiary's Suggestion on the Improvement of Selection of Technology

Health customers suggested different issues on the selection of technology. Most of the health beneficiary respondents 56.7% suggested that advanced technology should be provided. While 33.3% of health beneficiary respondents indicated that local demands should be considered to improve selection of technology. Overall, 10.0% of health beneficiary respondents indicated that there should be increase the use of information technology. This signifies that community is aware and understands the importance of being involved in the selection of technology of medical equipments.

Table 11: Health Beneficiary Suggestion on the Improvement of selection of Technology

Descriptions	Frequency	Percent
Provision of advanced technology	34	56.7
Local demands should be considered	20	33.3
Increase the use of information technology	6	10.0
Total	**60**	**100.0**

Source: Field Data Survey

4.6 The Role of Administrative Feelings on the Community's Contribution of Capital and Operations for Physical Facilities in Tanzania

Objective number four was designed to evaluate the role of administrative feelings on the community's contribution of capital and operations for physical facilities in Tanzania. The section covers the following sub sections; contribution of capital and operations for physical facilities and health customers' opinions on the contribution of capital and operations.

4.6.1 Contribution of Capital and Operations for Physical Facilities

Contribution of capital and operations for physical facilities has been helping delivery of decentralized health services. The findings in Table 12 revealed that, 53.3% of health beneficiary respondents contributed capital for physical facilities, while 46.7% of health beneficiary respondents did not contribute capital. This is because of either poor living condition of many people in rural areas that have been limiting them to access health services through contribution of capital facilities.

On the other hand, the contribution process was organized through hospital cashier's window as reported by one of key informants in Babati Town Council who said:

> *"Health beneficiaries contribute their capital through our cashier".*
>
> (Quote: From one of the Key Informants in Babati Town Hospital, 2018).

Furthermore, the study was interested to understand the amount contributed by health beneficiary for physical facilities. The results in Table 12 revealed, 81.7% of health beneficiary respondents were contributed between 1000-5000 T.shs. Besides, 16.7% of them contributed between 5000-10000 T.shs. Lastly, 1.7% of health beneficiary respondents contributed below 1000 T.shs. on the availability of physical facilities. The study realized that high cost is a barrier to many health beneficiaries to access health services. A similar case is reported by Hjortsberg and Mwikisa (2002) in a study on cost of access to health services in Zambia. It was suggested that, to reduce the cost of access, different options can be used. One way is to strengthen the first contact care, which is health resources going to first-level facilities in the Zambian health care Districts could increase. A mechanism to ensure

this is needed. It would certify that local health centers and health posts could provide high quality care with low cost, so they would not have to travel far to receive quality care. Also the provision of drugs to health districts should be ensured to avoid health care seeking at high prices. Another way to reduce cost of access is to provide home-based care and mobile health services in areas were individuals have limited mobility. Outreach clinics could provide basic health care and focus on major diseases, such as malaria and tuberculosis.

Nevertheless, health beneficiaries indicated reasons for contribution of capital for physical facilities. The results show that, 60.0% of them reported contributed by paying user fee (charges), while 40.0% of health beneficiary respondents reported contributed by paying for CHF. This implies that contribution of capital and operations was needed in the availability of physical facilities for the delivery of decentralized health services to be successful.

A report by World Bank (2002) on database for health, nutrition and population, found that, eighty-four per cent of the world's population lives in developing countries; they account for 93% of the global disease burden but only 11% of all health care spending. This implies that there is an inadequate provision of health care in many developing countries. Health care has to meet the needs of different population groups and at the same time not pose an impossible financial burden on households and on the national economy. Apart from this, general opinion is that the health care system needs to be equally accessible to the various social groups in the population.

Table 12: Contribution of Capital and Operations for Physical Facilities (N=60)

Variables	Descriptions	Frequency	Percent
Contributed capital	No	28	46.7
	Yes	32	53.3
Amount contributed (T.shs.)	<1000	1	1.7
	1000-5000	49	81.7
	5000-10000	10	16.7
Reason for contribution	Paying user fee (charges)	36	60.0
	Paying for CHF	24	40.0

Source: Field Data Survey (2018)

4.6.2 Health Beneficiary's Awareness on the Contribution of Capital and Operations

Awareness of health beneficiaries has influence on contribution of capital and operations on the availability of physical factors. The findings in Table 13 indicated that, 56.7% of health beneficiary respondents reported that contribution of capital improves health services on the availability of physical factors. While 30.0% of health beneficiary respondents confirmed that they were not interested to contribute. This is because most of them consider contribution of capital as the responsibility of central government. Fewer 13.3% of health beneficiary respondents indicated the increase of by-law sanctions. This implies that contribution of capital and operations was needed in the availability of physical facilities for the delivery of decentralized health services to be successful.

Table 13: Health Beneficiary's Awareness on the Contribution of Capital and Operations

Descriptions	Frequency	Percent
It improves health services	34	56.7
Not interested to contribute	18	30.0
Increase sanction by-laws	8	13.3
Total	**60**	**100.0**

Source: Field Data Survey

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary, the conclusions and recommendations together with suggestions for further research revealed from findings based on the objectives obtained in this study. The study aimed at investigating the impact of administrative attitudes on community participation in the delivery of decentralized health services in Tanzania. The study was conducted in Babati Town Council as a case study.

5.2 Summary of Findings

The findings showed that there is a need to improve the delivery of decentralized health services in Tanzania. Community participation should be improved so as to improve decentralized health services by changing the way of tempering it through administrative attitudes. The summary of the key findings are summarized based on the specific objectives of the study, objective one is designed to analyze the impact of administrative beliefs on the community's provision of labour and materials in the health facilities in Tanzania; it cover sub sections like available health facilities in the study area, community's provision of and labour and materials in health facilities. Others include administrative beliefs on community's provision of labour and materials and the impact of administrative beliefs on community's provision of labour and materials in health facilities.

Objective two is was designed to analyze the effect of administrative perception on the community's identified health needs and preferences for human resources, adequate drugs and funds in Tanzania; it cover subsections such as health needs and preferences followed by health customers, satisfaction of health needs, adequate of

health personnel and drugs, methods used by health customers to ensure health personnel and drugs. Other sub section includes participation of health customers in the selection of health needs, participation of health customers in the allocation and uses of funds. Finally is the effect of perception on the demand for health needs and preferences.

Objective three was designed to analyze the influence of administrative behaviour on the community's selection of technology and the location for medical equipments in Tanzania; it cover sub sections such as availability of medical equipments, participation of health customers on the selection of technology and health beneficiary's suggestions on the selection of technology.

Objective four was designed to analyze the role of administrative feelings on the community's contribution of capital and operations for physical facilities in Tanzania; it covers sub sections such as contribution of capital and operations for physical facilities and health beneficiary's opinions on the contribution of capital and operations.

5.3 Conclusion

The conclusion reached according to this study including the following observations obtained from the data presented, discussed and analyzed in the findings based on the specific objectives. Administrative attitudes in the organizational delivery of the decentralized health services, hospital networks, and other health care settings can greatly affect health outcomes, quality of care, and patient satisfaction. Therefore, this study examined the impact of administrative attitudes on community

participation in the delivery of decentralized health services in Tanzania; a case study of Babati town council.

First, the study revealed that most respondents in this study were married; there were female compared to male with the adult age and primary education level. Besides, the disparities in favour of women in the engagement in health-related information have also been suggested to have their deepest roots in culturally ascribed gender characteristics and behavior.

Secondly, the study revealed that health center and hospital had inadequate health facilities that cannot sustain the demands of the community dwellers in the study area. This statement shows that unavailable of crucial health facilities such as theater rooms in rural areas have been affecting the delivery of decentralized health services. The study findings are supported by Blunden *et al*. (2015), in a study on infrastructural challenges to better health in maternity facilities in rural Kenya. It was reported that lack of basic infrastructures including quality water and electricity supply has been associated with poor quality health services in rural Kenya.

Additionally, the study showed that most of health beneficiaries understand the importance of providing labor and materials to health facilities in the study area. This also was supported by one of the key informant during the interview. This statement indicates that the community understands the importance of participating and contributing labor and materials for availability of health facilities to improve health services for the betterment of their lives. But some of health customers were not aware of the community participation in the decentralized health services.

Moreover, the study assessed the kind of health needs and preferences followed by health beneficiaries. This implies that the health center and hospital provide different types of health needs preferred by community members as confirmed by health customers and one of the key informants in health center and hospital in Babati town council.

Furthermore, the study assessed health beneficiary satisfaction of health needs; this implies that half of health customers were not satisfied with the needed health needs or services preferred to them. Besides, Finkel (1997) concluded that, treatment satisfaction is included in the process component and is used as an important indicator of quality of health service delivery.

Likewise, the study assessed the adequacy of health personnel and drugs. This implies that inadequacy of nurses, pharmacists and doctors has been hindering delivery of decentralized health services. The International Pharmacy Federation (FIP) provided further evidence of the need for a Human Resources focus in Supply Chain Management through their Global Workforce Report in 2012. In that report it makes a linkage between lack of pharmacy personnel and inequalities in access to medicines. For example in Sub-Saharan Africa, on average less than one pharmacist was observed for caring 10,000 populations (FIP, 2012).

Thereafter, the study assessed methods used to ensure availability of adequate health personnel and drugs. This implies that community used different methods apart from health committee/ boards to ensure health personnel and drugs. These methods includes consulting community leaders and by writing proposal in village meetings.

It is observed that there is minimal community participation in the delivery of decentralized health services in Tanzania in terms of health committees and boards which act as representative of the community to the health providers. This is according to the surveyed respondents in Kinondoni MC and Ulanga DC by Marijani, (2017).

Similarly, the study reveals that there was minimal participation in the selection of health needs. Most of health customers participate in a planning stage and not in other stage such as implementation and evaluation. This is because health administrators perceive that community members have no skills to participate in evaluation of health programs.

Meanwhile, the study showed that community participated much in planning only which is passive kind of participation. This implies that the level of community participation in implementation and evaluation during the selection of health needs is minimal.

Thereafter, health beneficiaries were not fully participated in the allocation and uses of funds and the delivery of decentralized health services. This has been resulting to poor delivery of decentralized health services.

Also, the study assessed available medical equipments in the study area. It proves that the mentioned medical equipments were most used and preferred by health beneficiaries.

Moreover, the study assessed participation of community in the selection of technology. It revealed that there is poor community participation on the selection of technology.

Then, selection of technology for medical equipments has been affected mostly by the behaviors of administrators.

Thereafter, misuse of public resources including corruption hinders health beneficiary to access health services. Hence failure of delivery decentralized health services. Hence failure of delivery decentralized health services. This is supported by Fonn et al. (2015) in a study on corruption in the South African health sector. It was found that, misuse of public resources has a negative effect on patient care and the morale of healthcare workers.

However, poor living condition of most people in rural areas have been limiting them to access health services through contribution of capital and operations.

Thereafter, high cost is a barrier to many health beneficiaries to access health services. A similar case is reported by Hjortsberg and Mwikisa (2002) in a study on cost of access to health services in Zambia. A report by World Bank (2002) on database for health, nutrition and population, found that, eighty-four per cent of the world's population lives in developing countries; they account for 93% of the global disease burden but only 11% of all health care spending. This implies that there is an inadequate provision of health care in many developing countries.

Nevertheless, most of them consider contribution of capital as the responsibility of central government.

5.4 Recommendations

Basing on the conclusion of the findings, this study therefore, recommends the following way forward to overcome the setbacks encountered in the implementation process of decentralized health service delivery.

First, there is a need to ensure better equity in access to healthcare facilities for improvement of the delivery of decentralized health services. The number and quality of health facilities in a country or region is one common measure of that area's prosperity and quality of life (Ahmadi-Javid, *et al*., 2017).

Secondly, there is a need to enhance awareness creation to understand the importance of providing labor and materials for health facilities so as to improve the state of lower-tier health facilities serving communities.

Also, the government and health stakeholders should unite so as to increase the availability of health personnel and drugs.

Additionally, community should use different methods apart from health committees and boards which act as representative of the community to the health services needs. This might be the best ways for them in acquiring health needs for the betterment of the community.

Furthermore, for active community participation in delivery of decentralized health services there must be overall involvement so as to ensure availability of human resources and drugs.

Likewise, there is a need to involve community members in allocation of funds so as to increase transparency and accountability.

Meanwhile, for the absence and shortage of computers as the available medical equipments this calls for more interventions to increase computers in health services operations and programs to strengthen the delivery decentralized health services.

Thereafter, there is a need to increase community participation on the selection of technology including medical equipments due to the poor community participation on the selection of technology.

Also, it was suggested that, to reduce the cost of access, different options can be used. One way is to strengthen the first contact care, which is health resources going to first-level facilities in the Zambian health care Districts could increase. A mechanism to ensure this is needed. It would certify that local health centers and health posts could provide high quality care with low cost, so they would not have to travel far to receive quality care. Also, the provision of drugs to health districts should be ensured to avoid health care seeking at high prices. Another way to reduce cost of access is to provide home-based care and mobile health services in areas were individuals have limited mobility. Outreach clinics could provide basic health care and focus on major diseases, such as malaria and tuberculosis.

Also, contribution of capital and operations was needed for physical facilities for the delivery of decentralized health services to be successful.

Generally, the health centers expansion should be congruently go with health professional coverage, especially the gap of health officers coverage shall be given due emphasis.

The low satisfaction of the health office workers in budget allocation can be alleviated by allocation of budget based on office requirement and plan.

Councils should work hard to alleviate shortage of supplies in areas of medical equipments and supplies for the health sector.

The researcher strongly recommend Councils to use this study for making improvements in the stated area and; conduct additional researches using this study as a base.

5.5 Suggestion for further research

Community Participation is the key feature of recent policy reforms in the developing countries. The main objective of the study was to assess the impact of administrative attitudes in the delivery of decentralized health services at the community level in Tanzania; a case study of Babati town council. The study area represents all councils in the country in which this research problem is common and the literature review experienced the related topic elsewhere in the world. It is therefore suggested that, similar studies be conducted in other districts of Tanzania to get what is happening in the whole nation.

Further study should be carried out to investigate other impact outside the scope of this study that could be affecting community participation in the delivery of decentralized services in Tanzania; a case study of Babati Town council. It could also be important to find out the role of administrators in promoting community participation of decentralized health services. This is because it is the administrators who actually implement and develop the policy to be followed in achieving the vision of the community health services. Their roles can therefore not be withered away.

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APPENDICES

Appendix 1: Questionnaire for Health Beneficiaries

The University of Dodoma

College of Humanities Social Sciences

Department of Political Science and Public Administration

Masters in Public Administration

Dear Respondent,

This questionnaire is designed to investigate "*the impact of administrative attitudes on community participation in the decentralized health service delivery*" in hospital and health centers. Therefore, your honest and genuine response to the items in this questionnaire helps to meet the objective of this study. The information you provide will be used for academic purpose only and it will be kept confidential.

Section 1: Characteristics of the Respondents

Instruction: Please fill or put √ where appropriate

1. Name of health center/hospital………………………………………………

2. Number of respondent……………………………………….......................

3. Sex (a) Male ( ) (b) Female ( )

4. Age (a) < 20 years ( ) (b) 20-30 years ( ) (c) 30-40 years ( ) (d) > 40 years ( )

5. Level of Education: (a) Standard VII ( ) (b) Form IV ( )

(c) Diploma ( ) (d) First degree ( )

5. Marital status: (a) Married (b) single (c) Divorced (d) widow/widower ( )

Section 2: Questions related to the impact of beliefs on the provision of labor and materials in the health facilities in Tanzania (Objective-I).

1. How many health facilities available in your health area?

   Mention them……………………………………………………………..

2. Which health facilities are mostly used by health customers?

   Mention them and explain why?

   ....

3. Do you provide labor for the provision of health facilities in your area?

   (i) Yes (ii) No ( )

4. How do you provide labor for the provision of health facilities?

   Explain…………………………………………………………………

   …………………………………………………………………………………

5. Which materials do you provide to ensure the availability health facilities?

   Mention them………………………………………………………………

6. How administrators treat you in provision of labor and materials for availability of health facilities?

   …………………………………………………………………………………

   ……………………………………………………………………………….

7. How administrative beliefs affect community participation on the provision of labor and materials on the availability of health facilities? Explain

   …………………………………………………………………………………

   …………………………………………………………………………………

   …………………………………………………………………………………

   …………………………………………………………………………………

Section 3: Questions related to the effect of perception on the demand for health needs and preferences in human resources, adequate drugs and funds in Tanzania (Objective-II).

1. What health services/needs do you follow to the health center/hospital?

   (a) Immunization… (b) Family planning… (c) Pregnancy follow-up… (d) Clinic purposes… (e) Others (specify)…………………………………….

2. Do the health services provided meet your demands?

   (i)Yes (ii) No (   )

3. If No, explain why? ....

4. Are there adequate health personnel and drugs?

   (i)   Yes (ii) No ( )

5. If no, what do you do to make sure health personnel and drugs are adequate? Explain…………………………………………………………………………

   ………..

6. Do you participate effectively in the selection of health needs preferred by the community?

   (i) Yes (ii) No (   )

7. If yes, to what extent do you participate?

   …………………………………………………………………………………

   …………………………………………………………………………………

8. What is the extent of the community participation in allocation and uses of funds for health needs?

9. What are the effects of not involving the community in the selection of health needs basing on the preferences of local community?

Section 4: Questions related to the influence of behavior on the selection of technology for medical equipments in Tanzania (Objective III).

1. Which medical equipments do you prefer more in your health center/hospital? Mention them

   …………………………………………………………………………………

   …………………………………………………………………………………

   ………………………………………………………………………………..

2. Do you involve in the selection of technology on the availability of medical equipments?

   (i) Yes (ii) No ( )

3. In your opinions, how is the influence of administrative behaviors affect the availability of medical equipments in terms of technology?

   …………………………………………………………………………………

   …………………………………………………………………………………

4. What do you suggest on the selection of technology on the availability of medical equipments?

   …………………………………………………………………………………

   …………………………………………………………………………………

   …………………………………………………………………………………

Section 5: Questions related to the role of feelings on the contribution of capital and operations for physical facilities in Tanzania (Objective IV).

1. Do you contribute capital in improving health service delivery? (i) Yes (No)
2. How much do you contribute?

   (i) <1000 (ii) 1000-5000 (iii) 5000-10000 (iv) >10000 ( )
3. In which field/operations do you contribute capital for?

   Mention………………………………………..

   ....

   ....
4. What is your opinion on the contribution of capital and operations?

   ………………………………………………………………………………………

   ………………………………………………………………………………………

   ………………………………………………………………………………………

   ………………………………………………………………………………………

   .

Thank you for your cooperation.

Appendix 2: Interview Guides for Health Office Managers

The University of Dodoma

College of Humanities and Social Sciences

Department of Political Science and Public Administration

Masters in Public Administration

Interview Guidelines for Data Collection from Health Office Managers in Babati Town Council

1. How many health facilities available in your health area? Mention them

....

....

....

2. Which health facilities are most useful by health customers? Mention them and explain why? …………………………………………………………………

....

....

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3. How do you influencing the communities in the provision of labour and materials for availability of health facilities? ....

....

....

4. Do you think that adequate resources are deployed for health service provision in the Town Council level? Please explain on your answer……………………………..

....

5. Are there available and adequate health personnel and drugs (i) Yes (ii) No ( )

6. What is the extent of the community participation in the access and allocation of funds for health needs? --

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7. What are the effects of not involving the community in the selection of health needs basing on the preferences of local community? -----------------------------------

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8. Which medical equipments more available in your health center/hospital? Mention

them…………………………………………………………………………………

…………………………………………………………………………………………

…………………………………………………………………………………………

9. What do you suggest on the selection of technology on the availability of medical equipments?..

....

....

10. What is your opinion on the contribution of capital and operations?

………………………………………………………………………………………..

Thank you for your cooperation.

Appendix 3: Interview Guides for Health Station/center Level Stakeholders

The University of Dodoma

Collage of Humanities and Social Sciences

Department of Political Science and Public Administration

Masters in Public Administration

Interview Guidelines to collect data on Health Service Delivery in Health Institution/center Head and Head of Health Committee/Board

1. What are the major functions you currently practice in health service provision at health institution/center you are involving as committee in the council? …………

……………………………..

………………………………………………………………………………………

2. Are there stakeholders in health service provision that contribute in your institution/center? If yes, mention them……………………………………………..

………………………………………………………………………………………

……………………………………………………………………………………..

3. How and when did they contribute? ……………………………………………..

………………………………………………………………………………………

………………………………………………………………………………………

………………………………………………………………………………………

4. Do you think the community is satisfied with health service provided in the institution you are involving as committee?

………………………………………………………………………………………

....

5. How many health facilities available in your health area? Mention them

………………………………………………………………………………………

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6. Which health facilities are most useful by health customers? Mention them and explain why? ………………………………………………………………………

....

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....

7. How do you influencing the communities in the provision of labour and materials for availability of health facilities? ………………………………………………….

....

....

8. Do you think that adequate resources are deployed for health service provision in the Town Council level? Please explain on your answer………………………………

....

....

9. Are there available and adequate health personnel and drugs (i) Yes (ii) No (   )

10. What is the extent of the community participation in the access and allocation of funds for health needs? ---

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11. What are the effects of not involving the community in the selection of health needs basing on the preferences of local community? -----------------------------------

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12. Which medical equipments more available in your health center/hospital? Mention them………………………...

13. What do you suggest on the selection of technology on the availability of medical

equipments?...

....

....

14. What is your opinion on the contribution of capital and operations?

……………………………………………………………………………………………

……………………………………………………………………………………………

Thank you for your cooperation.