

ROLES AND CHALLENGES OF DECENTRALIZATION BY  
DEVOLUTION ON PUBLIC HEALTH SERVICE DELIVERY: A  
CASE OF DODOMA URBAN DISTRICT

By

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A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree  
of Master Arts in Development Studies of the University of Dodoma

The University of Dodoma

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**CERTIFICATION**

The Undersigned certify that they have read and hereby recommend for acceptance by the University of Dodoma thesis “*Roles and challenges of Decentralization by Devolution on Public Health Service delivery: A Case of Dodoma Urban District*” in fulfilment of the requirements for the degree of Master of Arts in development Studies of the University of Dodoma

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## **DEDICATION**

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## **ABSTRACT**

This study aimed at assessing roles and challenges of decentralization by devolution on health service delivery at Dodoma Urban District. The specific objectives were, to examine the role of Decentralization by Devolution in health service delivery in Dodoma urban district, to examine challenges of decentralization by devolution in health service delivery in Dodoma rural district, to examine the reasons of the identified challenges of decentralization by devolution on health service delivery in Dodoma urban District.

Cross-sectional survey design employed to undertake the research. The sample of 100 respondents was being selected purposively. Data were collected using questionnaires; interview and participatory observation and SPSS version 16 were used in the course of data analysis. The findings show that more than 60% of respondents were not aware on roles of decentralization by devolution on health service delivery this is due to top down approach during policy formulation.

Decentralization by devolution faced several challenges such as massive poverty, burden of diseases, politicization of the process and lack of clear fiscal autonomy between the LGAs and CG. These challenges curtailed the provisions of health services in terms of affordability and accessibility.

Poverty eradication strategy, education, participation, and commitment once instrumented the policy of decentralization by devolution will bare a positive result towards addressing the provisional of health service to majority of people at Dodoma rural District in timeless manner and quality manner.

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## **LIST OF ABBREVIATION/ACRONYMS**

MoLG	Ministry of Local Government
MTCT	Mother to Child Transmission
NHIF	National Health Insurance Fund
OPD	Outpatient department
PMO	Prime Minister's Office
RALG	Regional and Local Government
PO-PSM	President's Office - Public Service Management
SRDP	Sector Reform Development Programme
SRDP	Special Rural Development Program
TASAF	Tanzania Social Action Fund
THMIS	Tanzania HIV/AIDS and Malaria indicator Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
UNCDF	United Nations Capital development fund
UNDP	United Nation Development Program
URT	United Republic of Tanzania
W HO	World Health Organization
WB	World Bank
HRM	Human Resource Management
D by D	Decentralization by devolution
LGAs	Local Government Authorities
CG	Central Government
PHSD	Public Health service Delivery

# **CHAPTER ONE**

## **INTRODUCTION**

### **1.1 Overview**

The purpose of this study was to assess the roles and challenges of decentralization by devolution on health services delivery in Dodoma urban district. As an introductory part, this chapter it will include the background information, statement of the research problem, research objective, specific objectives, research questions, and significance of research.

### **1.2 Background to the Research Problem**

Globally, decentralization exercised differently in different countries, in different forms from both developed and developing countries. The term attracted attention in the 1950 and 1960 when British and French colonial administrations prepared colonies for independence by devolving responsibilities programmes to local authorities. In the 1980 decentralization came to the forefront of the development agenda alongside the renewed global emphasis on governance and human-centred approaches to human development and estimated that about 80% of the countries practiced decentralization in different forms (UNDP, 2008). Decentralization is highly linked with improving service delivery and improving micro- economic policy implementation thus decentralization by devolution become an ideal option.

Europe decentralization implemented concurrent with global trends for example in Germany, Austria and France, the precedence of the equalization of provision over public choice and economic incentives may leave open the likelihood that resource allocation will remain inefficient and lack discretionary flexibility. In Norway too, whilst provision is on the face of it relatively decentralized, a proliferation of directives, norms, and

standards reflect concern over equality of access and limit the scope for local governments to adjust to local preferences. It generally agreed that decentralization should carefully design to be transparent, with clearly defined competencies. This has different policy implication on countries involved on decentralization; within one country you can identify various degree of decentralization, depending on time of decentralization (Mutahaba, 1989).

However we can see that degree and type of decentralization vary by income. Countries with high incomes are likelier to adopt both fiscal and political decentralization. Despite of existence of all forms of decentralization worldwide, adverts believe that it planned according to the local needs and environment. For example Lithuania, Estonia, Latvia is examples of transition economies countries that are embracing decentralization as part of their transition to market economies that based to the local demands as it opposed to many African countries. The process of decentralization in Africa gain momentum over last two past decade's particularly through delegation and devolution UNDP (2008).

Tanzania has a lengthy history of decentralization dating back to colonial period, Arusha Declaration in 1967 and later Decentralization by Devolution (D by D), Meanwhile in June 1996, when the Prime Minister announced the government's decision to restructure and downsize regional administration with the objective of making local government more efficient and more effective (URT,1998). The "Policy Paper on Local Government Reform" of October 1998, which in rather detail outlined the vision of a future reformed public service. The policy paper is still the official guiding policy regarding local government reforms and decentralization by devolution. The vision for decentralization by devolution has supported through amendments of various pieces of LG legislation and some review of sector legislation, but not fully integrated (URT, 1998).

Historical overview of decentralization in Tanzania in terms of health service delivery most notable forms of decentralization commenced in 1960. Health Sector reform (HSR) also was oiled by Arusha Declaration in 1967 and 1970. Decentralization of health authority commenced from zonal referral to regional and district levels. Followed by the formation of national Health Policy in 1990 and reversed in 2003. Tanzania also is a signatory of different Health Convention like 1978 Alma Ata Declaration (WHO, 1978). Finally the most refined form of decentralization reforms in the health sector of Tanzania started in the 1980. Reforms intended to relinquish substantial powers and resources to districts to improve the development of the health sector and viewed as political and economic mode of life (Mshana, *et al.*, 2007). Since independence Tanzania adopted different decentralization measures to restructure its health system through introducing referral hospitals, zonal hospitals, regional hospitals, district hospitals and ward dispensaries. However, the health systems have been impaired in the following aspects; maternal death is 454 over 100,000 births in 2010, infant mortality rate is 51 over 1000 live births, still births is 26 over 1000 births 34.5% of people who use family planning, 52% of people who have access to family planning. HIV/AIDS prevalence rate is 5.7%, with all these but there are no enough professionals on many places, poor infrastructure like modern buildings, laboratory equipments, inequalities on health provision particularly to vulnerable children (Mubyazi, 2007).

Dodoma region made some progress in the following indicators regarding provision of public health service delivery since the inception of decentralization by devolution like, proportional of children under 1 year vaccinated against Measles in 2009 is 112% surpassed national level which is 91% (THMIS, 2009). Proportion of women receiving second dose of Tetanus vaccination is 87.7% while national level is 73.1%, deliveries in Health facilities in 2009 is 58.9% compared to National level which is 54.0%, percentage

of HIV positive women receiving ARVs to prevent mother to child transmission (MTCT) 2009 is 79.9% national total is 43.2% (THMIS, 2009). In Dodoma urban district poorly performed indicators in public health service delivery includes, Malaria prevalence is 13% compared to two leading regions in Lake Zone. High fertility rate, which is 6.5 children, compared to national fertility rate, which is 5.6 children per women lifetime, HIV/AIDS prevalence is low with 3.3% and women comprehensive knowledge in HIV/AIDS is 40% equal with the national average (URT, 2010). While Anaemia prevalence is 2% compared with national average that is 8%, per capita outpatient is 0.52% compared to national per capita outpatient, which is 0.74%. (URT, 2010)

These indicators evidently explain that there is a huge problem in health service deliverance despite decentralization by devolution, which took place for a number of years in Tanzania. Therefore, there is a need for conducting a study to explore what is exactly impaired in the decentralization in health system in Dodoma Urban District.

### **1.3 Statement of the Problem**

Since 1967 Tanzanian government decentralized its health system through deconcentration to increase service delivery to her local citizens. Health services are vital for any country development because it is attached to human lives and is a hub for economic and political development.

Decentralization by devolution leads to the replacement of the poorly coordinated projects by mechanisms for cooperation and dialogue, which aim at rallying all stakeholders behind national priorities. Decentralization by devolution raised the total public expenditure for health in Tanzania from 143 million US\$ in 1999 to 10452 million US\$ in 2008 and expanded domestic share of public health expenditures (from 46% to 65%),

increased availability and accessibility of primary services increased coverage of key child survival interventions like integrated management of childhood illnesses.

Regardless to the effort made by D by D on public health service delivery in Dodoma, still there are problems such as, acute shortage of qualified health professionals especially in the peri-urban areas of the region, huge diversity of pathologies and heavy burden of poverty related diseases increased costs for delivering health care and limited financial resources. The policy of Decentralization by devolution has not yet showed expected results. Therefore the study intended to investigate roles and challenges of decentralization by devolution on public health services delivery at Dodoma urban district and propose ways to overcome such challenges.

#### **1.4. 1 General objective**

The main objectives of the study were to assess the roles and challenges of decentralization by devolution on Public Health service delivery at Dodoma urban district.

#### **1.4.2 Specific objectives**

- i. To examine the roles of Decentralization by Devolution in health service delivery in Dodoma urban district,
- ii. To identify the kinds and reasons of challenges of Decentralization by devolution in health service delivery in Dodoma rural district.
- iii. To determine measures to improve D by D in health service provision.

#### **1.5 Research Questions**

The following questions will guide this research

- i. What are the roles of Decentralization by devolution in health service delivery in Dodoma urban district?
- ii. What are the kinds and reasons of the challenges of Decentralization by Devolution on health service delivery in Dodoma urban district?
- iii. Which measures should be taken to improve D by D in health services delivery in Dodoma urban district.

### **1.6 Significance of the study**

The findings made through this research will assist the government to evaluate the existing progress of Decentralization by Devolution (D by D) policy and revamp the impediments that are encountered during its implementation and operation. It will also enable to modify the Decentralization by Devolution that will lead into pro-poor policy and enable to improve the provision of health services with efficiency and cost effectiveness within the district, region, and country at large.

This study also act as the benchmarks for the government to emphasize more decentralization by devolution (D by D) that will improve health of its citizens and to achieve the Millennium Development Goal and even the Ruling Party Manifesto which clearly states on decentralization by devolution (D by D) as the means towards addressing health delivery challenges to its people.

In addition this study will provide empirical literature to various people who deal with policy analysis planning and monitoring and evaluation, while some of its recommendation arrange a foundation for further research and improving existing policy and hence expand the knowledge.

More specifically the study was enable the researcher to fulfil the requirement of the degree of Master of Development Studies at University of Dodoma.

## **1.7 Conclusion**

This chapter explained background to the problem of decentralization by devolution on public health services delivery. The statement of the problem highlighted the roles and existence of the challenges of decentralization by devolution on public health services delivery. The research objectives were roles, reasons, and kinds of challenges that faced the implementation of decentralization by devolution on public health services delivery. While the following chapter two presented a literature review, which provided detailed clues on the challenges of decentralization by devolution on health service delivery in Dodoma urban district.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Overview

This chapter is about reviewing of various literatures related to the study. The first part reviews intensively with theoretical literature review, whilst the second part is empirical literature review, the third part deals with conceptual framework and final part covers the knowledge gap.

#### 2.2 Theoretical Literature Review

##### 2.2.1 Conceptualization of the key terms and concepts.

**Roles;** can be defined as static collection of privileges that define broad user access rights and definitions. However, for the purposes of the study role refers to the functions assumed or part played by decentralization on services delivery (*Ibid*)

**Challenge;** can be defined as something that needs a lot of skills, energy and determination to deal with or to achieve especially something you have never done before and enjoying doing it. For the purpose of this study challenges mean all threats that encounter decentralization by devolution policy with exceptional of problems (Burke, 2008).

**Decentralization by Devolution (D by B);** can be defined as the transfer authority for decision-making, finance, and management to quasi-autonomous units of local government (LG) with corporate status. Devolution usually transfers responsibilities for services to municipalities on district councils, that elect their own mayors and councils, raise their own revenues and have independent authority to make investment decisions (JICA, 2008). For the purpose of this study decentralization by devolution will mean the

process in which the governments devolve functions, they transfer authority for decision-making, finance, and management to quasi-autonomous units of local government with corporate status.

**Public;** means the people of the nation, state, county, district, or municipality, which the government serves. However, for the purpose of the research the term public is referring to any agency, interest, property, or activity which is under the authority of the government or which belongs to the people (Robert and Denhardt, 2009).

**Health;** World Health Organization (2008) defined health as a "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." Health is a dynamic condition resulting from a body's constant adjustment and adaptation in response to stresses and changes in the environment for maintaining an inner equilibrium called homeostasis.

**Service;** can be defined as product delivered or activity that carried out advice interpretation that the user (Burke, 2008) apply meets the needs of a user or that. For the purpose of the study service will mean any output delivered by public health system in Tanzania both curatives, preventives measures.

**Service delivery;** is the continuous process for developing and delivering user focused services, defined by user engagement, service design and development, service delivery, and evaluation and improvement (Burke, 2008).

**Health services delivery;** World Health Organization (2010) defined health service delivery as the way inputs are combined to allow the delivery of a series of interventions or health actions, it is focusing on contracting, essential drugs management, health services management, human resources, non-state providers, quality improvements. For the purposes of the study a study will adopt the definition of WHO (2010).

**Public health service delivery;** can be defined as the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. Public health service delivery is concerned with protecting the health of entire populations. These populations can be as small as a local neighbourhood, or as big as an entire country (WHO, 2010). It includes a set of biological, epidemiological, social, and statistical sciences and practices intended to measure, protect, and promote health on a population level. Public health overlaps many fields of medicine, given the growing population focus of biomedical research, the increasing concern with bioterrorism, and the importance of epidemiological methods in clinical trials. The concept is focusing on the role of public or government renders basic health services at large. (WHO, 2010)

**Decentralization;** is often used as concept without strict definitions, each country exercised differently. The term decentralization has become a catchy word on many developmental debate underpinning both developed and developing countries. The World Bank (WB) defined Decentralization as the transfer of authority and responsibility for public functions from the central government (CG) to intermediate and local government (LGs) or quasi-independent government organizations and/or the private sector, is a complex multifaceted concept. Different types of decentralization should be distinguished because they have different characteristics, policy implications, and conditions for success (JICA, 2008). Under this study it will solely use decentralization as the power transfer from central government to local ties like municipalities and district councils.

Moreover (Elsageer and Mbwambo, 2004) defined decentralization as the transfer of responsibility for planning management, and resources utilization and allocation from central government (a) Field units of central government ministries; or agencies (b)

subordinate units or levels of government; (c) semi-autonomous public authorities or corporations; (d) area wide regional functional authorities. This definition has broad arrays to contextualized decentralization that suits in African context, at large and Dodoma in particular, and enable to avoid vagueness attached to the meaning to have clear vista on the practical meaning of decentralization.

In contrast to above definitions (Larson and Ribot, 2004) introduce the new emancipatory language of democracy, pluralism and right this new direction, a distinction is made between democratic decentralization and deconcentration. Democratic decentralizations also called political decentralization or devolution involves the transfer of power to elected local authorities (Ribot, 2004). Democratic Decentralization integrates local population into decision making through better representation by creating and empowering representative's local governments which have autonomous domain of powers to make and implement meaningful decisions. Thus this definition introduces the new impetus of democracy in decentralization; it will be so useful because it enables the study to explore the demand of the local people that tailor their needs by being active participant on their activities endeavours.

Decentralization involves basic four approaches namely deconcentration, delegation, devolution and privatization;

#### **(a) Decentralization by Deconcentration**

Deconcentration is often considered to be the weakest form of decentralization; it redistributes decision making authority and financial and management responsibilities among different levels of the central government (CG) (JICA, 2008). It can merely shift responsibilities from central government officials in the capital city to those working in regions, provinces or districts, or it can create strong field administration or local

administrative capacity under the supervision of central government (CG) ministries. It implemented in Tanzania in early 1972 as “*Madaraka Mikoani*” which were established primarily by political motives rather than economic motives and it was not fully decentralization of local authorities (URT, 2008)

#### **(b) Decentralization by Delegation**

Delegation is a more extensive form of decentralization. Through delegation central governments transfer responsibility for decision-making and administration of public functions to semi-autonomous organizations not wholly controlled by the central government (CG), but ultimately accountable to it. Governments delegate responsibilities when they create public enterprises or corporations, housing authorities, transportation authorities, special service districts, semi-autonomous school districts, regional development corporations, or special project implementation units (JICA, 2008).

#### **(c) Decentralization by Devolution**

The term Devolution is defined as the transfer authority for decision-making, finance, and management to quasi autonomous units of local government (LG) with corporate status. Devolution usually transfers responsibilities for services to municipalities or district councils, that elect their own mayors and councils, raise their own revenues and have independent authority to make investment decisions (JICA, 2008).

#### **(d) Decentralization by Privatization**

Privatization defined as the form of decentralization where the central government decides to privatize some of the activity or services that formerly performed by central government to private firms to increase efficiency in service delivery (URT, 2008).

### **2.2.2 Theoretical Frame work**

### **2.2.2.1 Roles of decentralization by devolution on health service delivery**

Theories tell us that decentralization can lead to a number of positive outcomes (Schults and Yaghmour, 2004); some of the positive outcomes include democratization and participation, rural development public service performance and poverty alleviation. Thus the study revisited various theories in order to envisage and to have a clear vista on the nature of problem thus to nourish research findings.

#### **i. Efficiency value theory**

Efficiency values comprise of the public choice justification of decentralization, where efficiency is understood as maximization of social welfare. This theory lies, on the fact that the people themselves are the hub to initiate their needs for decentralization. The public at large influence change on their community. Decentralization adverts believed that the public is the driver for change. Hence even the government should strive to empower people through democratization which translated into decentralization by empowering the people to participate on decision making process to address opportunity and obstacles impaired their daily activities along their jurisdiction.

#### **ii. Governance Value Theory**

Governance Value theory of decentralization include responsiveness accountability diversity and political participation. The first value responsiveness and accountability are the most important of by bringing greater participation in public decision making improve efficiency equity on the provision of public health services that tailor to the local needs Cook (2003) argues that decentralizations plays an important role in democratization and people participation, public service performance, poverty alleviation, political and macroeconomic stability. Decentralization is widely believed to increase public sector accountability and therefore effectiveness (OECD,2004).This theory is most useful in this

study because it will enable a researcher to analyze the potential benefit that decentralization entail to bring to people particularly health sector which become a great challenges in Tanzania.

### **iii. Organization Theory**

Organization theory of decentralization (departmentalization) is the policy of delegating decision making authority down to the lower level in organization, relative away from and lowering central authority, decentralized organization shows a fewer tiers in the organizational structure, wider span of control, and bottom-to –top flows of decision – making and flow of idea. (URT, 2008). In many organizations decision are following a scalar chain thus such vertical accountability increase complexities and rigidity on many organizations. Hence there were needs to reverse the model so that to increase participation and involvement of grass-root community on decision making process. This theory is useful in this study; it enables to understand the nature and forms of decentralization that would be more plausible to response to the local needs while embracing the entire community into fully participation.

### **iv. A Sequential Theory**

A sequential theory of decentralization has three main characteristics: (a) it defines decentralization as a process; (b) it takes into account the territorial interests of bargaining actors; and (c) by incorporating policy feedback effects, it provides a dynamic account of institutional evolution.

Decentralization as a Process; It defines decentralization as a process. It is a set of policy reforms aimed at transferring responsibilities, resources, or authority from higher to lower levels of government. The concept is not used as an adjective to qualify a given political or fiscal system. Decentralization is a set of state reforms. As such, decentralization does

not include transfers of authority to non-state actors (as in the case of privatization reforms).

In general, the decentralization reforms followed the collapse of the developmental state and accompanied the move toward free-market economies characteristic of the last quarter of the twentieth century. Finally, decentralization reforms may take place in authoritarian as well as democratic contexts, which means that the concepts of decentralization and democratization should not be conflated. It classifies decentralization policies as belonging to one of three categories administrative, fiscal, and political depending on the type of authority devolved. Administrative decentralization comprises the set of policies that transfer the administration and delivery of social services such as education, health, social welfare, or housing to sub national governments. Administrative decentralization may entail the devolution of decision making authority over these policies, but this is not a necessary condition. If revenues are transferred from the centre to meet the costs of the administration and delivery of social services, administrative decentralization is funded (and coincides with fiscal decentralization). If sub-national governments bear the costs of the administration and delivery of transferred services with their own pre-existing revenues, administrative decentralization is not funded. This theory is plausible under this research because it's linked with specific objectives of the research: roles of D by D, to improve D by D in public health provision.

Four theories will be taken into consideration to explain the role of decentralization by devolution on health service delivery. The first one is efficiency value theory of decentralization developed by James Wolman 1997 (Elsageer and Mbwambo, 2004). According to efficiency value theory of decentralization one of the roles of decentralization by devolution is to act as a watch dog by strengthening of the local

government authority financial management capacity. Decentralization by devolution enable efficiency on the provision of health services by enabling and supporting the implementation of improved financial management systems. Like the national Integrated Financial Management System (IFMS) which uses a computer software called (EPICOR) is gradually being introduced in close collaboration with the Ministry of Finance and Economic Affairs (MOFEA). At present, majority of the LGAs are on this electronic financial management platform system. These various financial management efforts are beginning to bear fruit as evidenced by the improved quality of annual financial reporting by LGAs. In the year 2000, 65% of LGAs received adverse audit reports from the National Audit Office; compared to 23% in 2002, and less than 4% in both 2005 and 2006. This enable the provision of health service by reducing corruption and tedious work of preparing salaries for its workers (URT, 2008).

The second theory is a Governance Value Theory of decentralization developed by Wolman in 1997 (Elsageer and Mbwambo, 2004). The value theory of governance suggested that decentralization will increase responsiveness to the local needs, increases accountability, diversity and political participation. Building capacity to the Health workers, the governance value theory of decentralization pin pointed that the role of decentralization by devolution is to increases responsiveness accountability diversity and political participation .The first value responsiveness and accountability are the most important of by bringing greater participation in public decision making improve efficiency equity on the provisional of public health services that tailor to the local needs (Crook and Manor, 2008).

The third theory is organization theory of decentralization or (departmentalization) propounded by Gulick Luther and Urwick Lyandal 1937 (Gulick and Urwick 1937). The

theory explains the process of power transfer through departments. As the policy of delegating decisions, authority down to the lower level in organization. More relative away from central authority .A decentralized organization show a fewer tiers in the organizational structure ,wider span of control ,and bottom-to –top flows of decision – making and flow of idea (URT,2008).This cater for more participation to the local communities towards fully participation to their own raised projects including health services. Therefore the role of departmentalization is to have a span of control and chain of command from the central government to local government.

Through organization theory the ministry of health role will able to clarify, describe, and classify, major responsibilities within health sector to coordinate with other stakeholders to deliver health services to local people at their jurisdiction. This includes clarifying the relationship with the regional level, and on the role, mandate and authority of the Regional Administrations, (RAs) According to governance theory of decentralization many organizations decision are following a scalar chain which increasing cost-consciousness and efficiency on service production to secure links between resource allocation and utilization. Moreover is to amplify health worker motivation through local supervision and involvement of service users in oversight, performance assessment (URT, 2008)

The fourth theory is the Sequential theory of decentralization developed by Fallet Tulia 2005 (Falleti,2005) the role of decentralization on public health delivery is the provisional of policy feedback through undertake measurement and Evaluation of socio-economic development, public health service delivery and poverty reduction by LGAs in the areas of their jurisdiction and systematic and regular communication of the trends and results to the citizens for better awareness on the ongoing issues (URT, 2008).

### **2.2.2.2 Challenges of decentralization by devolution on health service delivery**

Four theories will be promulgated to explain the challenges of decentralization on public health services delivery namely the principal model theory, the top down theory, viscous cycle of poverty theory and fiscal decentralization theory.

#### **i. Principal – Agent Theory**

The first theory is the principal- agent theory developed by Arrow and Wilson in 1960 and 1970 (Kathleen, 1989). The underlying assumption is that the agent's interests may differ from those of the principal. The most common challenge on decentralization by devolution on public health service delivery is a lack of common vision and commitment to a model of decentralisation by devolution, although the vision for Local Government Reform is clearly stated in the Local Government Reform Agenda 1996–2000, the Local Government Reform has been frustrated by lack of common vision and commitment to a model and system of local Government Reform. Eventually, the implementation of the Reforms has apparently faced reluctance from central government institutions to devolve powers, functions and resources to Local Government Authorities. The central government as the principal is reluctant to decentralize power to local authorities, while the agent demanded for changes has curtailed the pace for decentralization (URT, 2008).

#### **i. Top- Down Theory**

The second theory explains the challenges of decentralization by devolution in health service delivery is the top - down theory developed by Van Meter and Van Hon (1975). This theory explains the existence of policy contradiction and legal frame work and made decentralization as alien to local environment. Decentralization designed from other environment wouldn't function similar due to existence of pre conditions that differ from one place to another place. In Tanzania for example there is existence of non D by D

policy and legislative framework; on many areas the legislative bottlenecks affect the operation within health service delivery. Despite of implementation of LGRP still there bottlenecks on implementation of decentralization by devolution on public (PMO-RALG, 2008).

Moreover the top-down theory creates another challenge for being prescriptive (modus operandi) by provide policy guidelines to local people rather than accommodate local needs hence become difficult to implement decentralization on vast areas with heterogenic and complex needs toward police directives. These trends have weaken local government to mobilize her own source revenues like property rates and others which are necessary to co-finance health services, enhance a locative efficiency and strengthen local governance accountability. This challenge the provision of health services despite of articulated local government could collect her levy yet it is enshrined by central government (URT, 2008).

## **ii. Viscious Cycle of Poverty**

The third theory is Viscous cycle of poverty developed by Ragnar Nurkse (1953) the theory explain the challenge of decentralization by devolution on public health service delivery by earmarking poverty as the major challenge towards decentralization (Herrera, 2006). Many local governments have limited financial and human resources and inadequate governance capacity to fulfil the mandate thrust upon them. Many of our municipal governments lack the necessary institutional capacity to manage their rapidly growing populations hence decentralization on public health delivery failed to deliver it intended goal to local population and being criticized for being decentralized poverty and not services that tailor local needs.

### **iii. Fiscal Decentralization Theory**

The fourth theory is the theory of Fiscal Decentralization developed by Tiebout's (1956) in its seminal article (Wellisch, 2000). Despite of global demand for fiscal decentralization but there is completion between central and local government towards distribution of sources of revenue between central and local government. The allocation of resources between Central and Local Government is made in contravention of this basic principle in the sense that allocation of resources between Central and Local Government is un-proportionally aligned with functions as evidenced in 2008/09 budget where the share of the LGA's budget was only twenty percent (20%) of the total government budget (URT, 2008).

#### **2.2.2.3 Reasons for challenges of D by D**

Four theories have been used in order to explain reasons for the challenges face decentralization by devolution on public health service delivery.

##### **i. Participatory Liberal Theory**

The first theory is participatory liberal theory established by Peter Bacharach 1967; the common thread in a participatory liberal theory is the desirability of maximizing the participation of citizens in the public decisions that affect their lives. One of the most common reasons for challenges of decentralization is the participation in many instances the local community become the passive recipient of the policy formulation. This enhances local people to fail to own the process and shy away from many community activities as emphasized through decentralization by devolution (Myra *et al.*, 2008).

##### **ii. Mismatch between authority and responsibility Theory**

The second reasons for these challenges is the mismatch between authority and responsibility this problem can be found in many different forms of decentralization , for

instance, within sectoral decentralization efforts or between administrative and fiscal decentralization. An example of the former is when responsibility for managing public health workers is devolved to regional or municipal health units, but the central ministry retains authority for hiring, firing, and promotion of staff. Local governments are responsible for health care spending, but have no revenue-raising authority. Another variant arises when central units assign additional responsibilities to regional or local health sector agencies, but provide no additional resources unfunded mandates (Nick, 2005).

### **iii. Discursive Theory**

The second theory is the discursive theory developed by Peter Bacharach in 1967 this theory explains the main reasons for challenge of decentralization by pointing out who should be included in the public sphere (Myra *et al.*, 2008). The presence of autonomous actors communicates in a different way they are free from the burden of making decisions and from the constraints of organizational maintenance. This allows them, in contrast to other actors; to deliberate more freely they can more easily take the viewpoint of other actors and respect the better arguments.

### **iv. Constructionalist Theory**

The third theory is the constructionist theory developed by Nicholas Onuf in 1989 explores the existence hidden inequalities in many communities. They are more pessimistic than discursive theorists about the possibility of separating oppressive power from speech (Myra *et al.*, 2008). This theory explain the reasons for the challenges of decentralization by examining the existence of inequalities that on the decentralization process both civil society and community have been not empowered fully, the government is more powerful and dominate the process and deprived the rights of people. This creates

tensions and conflicts among local communities and in some cases, devolution can lead local health providers to respond to local preferences for curative rather than preventive and primary health services (Nick, 2005).

#### **v. Elitist Democracy Theory**

The fourth theory is the elitist democratic theory preponderated by Elmer Schattschneider (1960) which explains the reasons for challenges facing decentralization by devolution on health service delivery through internal conception of power that explains the power of people with the government and the possibility of overcoming the elitism of political structure (Myra *et al.*, 2008). The political and process dimensions, of decentralization are profoundly political, while there are many strong technical arguments in favour of health sector decentralization, without attention to the politics of decentralization. Nevertheless, politicians have won the agenda and hijacked it and the practitioners failed to implement it well due to frequently intervene and deprives to elicit their technical expertise (Nick, 2005).

The Relevance of nine Theories namely; T Principal – Agent Theory, Top- Down Theory, Vicious Cycle of Poverty, Fiscal Decentralization Theory , Participatory Liberal Theory, Mismatch between authority and responsibility Theory, Discussion Theory, Constructionalist Theory, Elitist Democracy Theory and to D by D in to this study concern their direct application or use in LGAs for higher workplace performance. The LGAs need to be effective and accountable in delivery of quality public services to the citizens. Therefore, the study adopted the theories together with the other challenges and reasons for challenges theories to under the problem in Dodoma urban district.

## **2.3 Empirical Literature Review**

### **2.3.1 History of decentralization Worldwide**

Worldwide decentralization has a long history exercised since the emergence of Ancient civilizations but in different forms. An excellent example is the gradual political and organizational changes that have occurred in European history. During the rise and fall of the Roman Empire, Europe went through major centralization and decentralization. The overlapping issues of fiscal federalism and decentralization that had earlier received little attention on part of political scientists and economists became the theme of international professional interest by 1990's and have continued to attract attention of the specialists and policy makers ever since (Sharma, 2005).

African governments have undergone repeated decentralization reforms since the early colonial period. However, in the most recent wave (beginning in the late 1980), the language of reform has shifted from an emphasis on national cohesion and the management of local populations to a discourse more focused on democratization, pluralism and rights (Sharma, 2005).

Decentralization is not new in Africa. Since 1917 there have been at least four waves of decentralization in Francophone West Africa after each of the World Wars, shortly after independence in the early 1960, and in the current decade. Some Francophone Central African countries also decentralized just before independence and others after independence. The Anglophone and Lusophone African countries have also seen multiple pre- and post-colonial decentralizations. At independence African governments inherited a system in which local governments were tools of administrative management. Under this system, so-called "customary" authorities were privileged as the "representatives" of

the rural world and the prefects, commandant's des cercles and district officers were the appointed supervising managers (Blair, 2000).

In the post-colonial period local government had two prominent features, one regardless of regime type, ruling groups sought to control local-level public affairs, and secondly local social groups generally avoided or disregarded sub national political- administrative organizations. After independence, governments across Africa continued to use local governments as administrative units, and major functions of local governments such as health care, education, road construction and local taxation were transferred to central government control (Jesse, 2002)

In the 1980 and 1990, Structural Adjustment Programmes (SAPs), requiring the cutting down of central governments, forced many governments to develop decentralization reforms. With the fall of the Berlin Wall and the elections in South Africa, these reforms were infused with a new, more democratic language. As one United Nations agency emphasized in the 1990, "political decentralization has assumed a new meaning, away from the imposition of centralized monolithic values, towards a much more rights-based culture" (UNCDF, 2000). Decentralization is now being promoted in a context of pluralist discourse, emphasizing greater representation of citizens as well as state reforms toward market-based development with structural adjustment programmes.

Decentralization is transforming the structure of governance in Africa. Since the middle of the 1980's most African countries have started a transfer of power, resources and responsibilities to their sub national governments. The pace of transformation is very uneven across countries. A few countries namely, Ethiopia, South Africa and Uganda are proceeding fast. A number of countries have just started the process and are presently creating new units and/or transferring responsibilities and revenues to them. A large group

has only adopted legal texts that engage the central government to proceed towards a more decentralized system (Jesse, 2002).

In the 1990s the discourse on decentralization began to highlight “democratic decentralization” as the preferred reform (UNCDF, 2000). Furthermore reforms taking place in the name of democratic decentralization have neither created the accountable, representative local institutions nor devolved the powers that would constitute democratic decentralization. Decentralization in East Africa took a similar fashion like her many African countries counterpart. Like Tanzania Kenya and Uganda have many differences social economic and political set up but they all share a common denominator which is massive poverty. As the case of Kenya has a long history of decentralization stretched since 1902, the Village Headman Ordinance was passed by British (Crook and Sverrisson, 2001).

The independence constitution of Kenya provided for regional government under KADU but come to an end in 1964 following re-establishment of provincial Administration was re established and empowered which went regrettably to increase concentration of power to central government. In 1971 the Introduction of bottom- up approach (SRDP) elapsed in 1974. In 1983 (DFRD) replaced (SRDP) which initiated with the goal of institutionalizing participatory bottom-up approach development (UN-HABITAT, 2001). District development commission (DDCs) was established under the chairmanship of the district commission (DC) and secretary ship of district development offices (DDO). Following the 1980s the wave of changes has swiped Kenya to foster more recently forms of decentralization. Such changes pioneered by both internal demands and external pressures such as needs for rapid development, microeconomic imbalances globalization

and World Bank and IMF conditionality for decentralization. Kenya adopted MDGs and PRPs which entails further decentralization (World Bank, 2000/2001).

Uganda has experienced decentralization both as a system and process of devolution of power from the central to local authorities'. Historically three main phases of decentralization can be distinguished (MoLG, 2006). In the first phase (1955 to 1964) a strong local administration system was created in the context of weak center. The second phase (1964 to 1985) featured re-centralization of power and severe weakening of local administration. The third phase (1987 to date) has been characterized by significant devolution of power to local authorities through programs to strengthen local government systems. The Uganda National Resistance Movement initiated the current system of decentralization as part of a broader strategy to restore state credibility and deepen democracy. The decentralization system emanated from the creation of local councils as instruments for political and economic empowerment through programs to improve service delivery and accountability (John and Madina, 2006).

Tanzania has a long history of local government, it dates back since colonial period, even the government's commitment to enhance community participation in development planning and budgeting has emanated from the Constitution of the United Republic of Tanzania, 1977, Articles Numbers 145 and 146, which aim at transferring authority to the people through establishment of Local Government Authorities (LGAs) (JICA, 2009). According to the articles, LGAs are charged with the rights and powers to involve the people in planning and implementation of development programs within their areas of jurisdiction, strengthening democracy to speed up community development (JICA, 2009). Tanzania Local Government history transcended on different phases 1970s was abolished and were re introduced in 1982s, in the early 1990s ("African Perestroika"), the intention

to reform LGAs was part of the Civil Service Reform Program (Mmari,2005). Decentralization then also featured in the CCM Election Manifesto of 1995 and was later developed into the LG Reform Agenda Vision of 1996. In 1998, the Government of Tanzania approved the Policy Paper on Local Government Reform, which is the basis for the ongoing Local Government Reform Program (LGRP), whose implementation started in 2000 (JICA, 2009). The stated objective of the LGRP I was to “improve the quality and the access to, public services provided throughout or facilitated by LGAs”. After the first phase of the LGRP ended mid of 2008, the LGRP II was finally agreed beginning of 2010 between the government and development partners supporting the decentralization process. Based on the experiences of the preceding phase, LGRP II focused on three components: Improving the framework for decentralization at the national level. Further capacity development of LGAs (including the lower level), and strengthening downward accountability and political participation of the citizens. The LGRP is one of the core reforms of the Tanzanian Government (besides the Public Financial Management Reform, the Public Service Reform, the Anti-Corruption Strategy, and the Legal Sector Reform). At the end it has to be the LGAs that have to deliver at least 80% of all public services (JICA, 2009).

### **2.3.2 Roles of Decentralization by devolution on health service delivery Worldwide**

Until 1970's the development process of many countries in Europe, Asia America and Africa and other developing countries elsewhere was centrally controlled (Schults and Yaghmour, 2004). Due to failure to achieve the expected development, policy makers and planners started to think of alternative forms of management that could bring about the needed development. Decentralization is increasingly seen as an attractive framework for health system organization and management, incorporating elements of local control with hoped-for efficiencies in the management of financial and human resources. Globally

decentralization plays the following important roles on health service delivery. Schults and Yaghmour (2004) pointed out the argument that the role of decentralization on health service delivery includes democratization, public service performance and poverty elevation, increases of participation which in turn increases efficiency and equity in health service delivery. Building capacity to the Health workers, decentralization by devolution, increases responsiveness, accountability diversity and political participation. The first value responsiveness and accountability are the most important of by bringing greater participation in public decision making improve efficiency equity on the provisional of public health services that tailor to the local needs (Crook and Manor, 2008).

The other role of decentralization by devolution in fostering better stewardship was needed to facilitate improvement in the performance of health system functions such as service provision, resource generation and health system financing (WHO, 2010). Good stewardship requires a sound economic situation, supportive political environment and coalitions of support from stakeholders at all levels for success. Stakeholders' analysis and management are important undertakings to ensure success of the reforms.

To enhance active participation of stakeholders in the production of health, the strategy included emphasis on self-reliance and community participation. To empower households and communities with knowledge and skills needed to reduce the burden of disease to people to enable them to overcome health problems to their jurisdiction. strong political commitment to improving health, as reflected in preferential government spending and inter-sectoral perspectives in planning and operating systems of health care; appropriate organizational framework and managerial process; equitable distribution of health resources and community involvement (Massoi and Norman, 2009).The other role include to improve health status and consumer satisfaction by increasing the effectiveness and

quality of services to obtain greater equity by improving the access of disadvantaged groups to quality care. To provide health services which is cost-effectiveness from health spending, considering improvements in both the distribution of resources to priority activities (allocation efficiency) and the management and use of the resources that have been allocated (technical efficiency) (Massoi and Norman,2009).To provide feedback through undertake measurement and Evaluation of socio-economic development, public health service delivery and poverty reduction by LGAs in the areas of their jurisdiction and systematic and regular communication of the trends and results to the citizens for better awareness on the ongoing issues.

The role of decentralization by devolution in Tanzania includes strengthening LGAs financial management capacity. Decentralization by devolution enable efficiency on the provision of health services by enabling and supporting the implementation of improved financial management systems, increases responsiveness accountability diversity and political participation, the first value responsiveness and accountability are the most important of by bringing greater participation in public decision making improve efficiency equity on the provisional of public health services that tailor to the local needs (Crook and Manor, 2008). To enhance citizen participation and downward accountability to clients are increasing aware of health service delivery and their rights to access it, and increases propensity of public servants to be accountable for service delivery results (URT, 2008). Regardless of the roles of played by decentralization by devolution in health service delivery the situation in Tanzania is worse hence the study aiming to identify the role of Decentralization by devolution in health service delivery in Dodoma urban district.

### **2.3.3 Challenges of decentralization worldwide**

Global challenges of decentralization by devolution in health service delivery include Political will, leadership and ownership this creates a serious challenges on health service delivery in Central Asia and the Western CIS countries, is often simply the absence of political will to develop and implement reform strategies (Azerbaijan, Turkmenistan and Belarus) are cases in point (UNDP, 2008). The presence of authoritarian tendencies coupled with the desire to maintain the status quo which benefits a given elite is a major obstacle to reform. Where attempts for reform have been initiated in these countries, they have been hampered by the absence of a clear understanding of the role of the modern state and have resulted in the inability to reach consensus on the distribution of responsibilities between different levels of government (UNDP, 2008). Given its complexity and highly political nature, decentralization requires a strong institution or political figure (a ‘reform champion’) to lead the process, reconcile conflicting interests and make choices which are politically and technically difficult. In Georgia or Serbia, for instance, the absence of a key figure or institution to lead decentralization efforts has led to a serious lack of coordination (Ahmad, *et al.*, 2005).

In some countries of the Western Balkans in particular, the responsibility to implement decentralization reforms has been assigned to ministries that do not have the political authority to lead, coordinate and enforce the reforms, particularly at the sectoral level where ministries are keen to retain their decision-making powers (UNDP, 2008). The absence of strong political leadership often reflects the fact that decentralization was not the result of domestic processes but was ‘imposed’ from outside to achieve broader sub regional political objectives (Linder, 2004)

In many of the Europe and CIS countries, lack of political will and ownership of decentralization also prevails at the local level. Poor communication on the part of central government as to what the objectives of decentralization are and what the process entails has left local governments with the common perception that decentralization is merely about distribution of revenue in their favour. Such perceptions have not been conducive to a constructive dialogue between the central and local authorities and the formulation of realistic decentralization policies characterized by ownership and commitment of all (Ahmad, *et al.*, 2005)

Institutional capacity to design, implement and monitor decentralization the underestimation of the complexities of the decentralization process by the political elite and the excessively legalistic approach towards reform have been two major causes for poorly conceived and implemented decentralization. The absence of capacity and mechanisms to monitor the implementation of reform has prevented the timely identification of emerging issues and the adoption of corrective actions. In many countries, even when the necessary legislation was put in place it was not backed by the necessary institutional capacity at the central and local level to implement it. In others, poorly designed reforms have sometimes lead to paradoxical situations where a strategic and policy framework exists but it is not backed by the full range of required legislative reforms Turkey and Macedonia (UNDP, 2008).

Weak policy capacity at both central and local level is a common feature in the commonwealth independent states region. Decentralization has often implemented separately from a systematic and comprehensive approach to public administration reform. The lack of clear division of responsibilities for specific competencies, especially related to the shared functions in Albania, has often led to concurrent authority, with

duplication or under-provision of essential services. The practice of devolving responsibilities without building the necessary local capacities or supporting ‘on the job’ learning has been common. Measures to reform government structures have not taken into account the need for an appropriate scale for the efficient delivery of key services (Ahmad, *et al.*, 2005). For instance, Macedonia applies ‘one size fits all’ decentralization (all municipalities irrespective of their size have the same devolved responsibilities) despite the fact that approximately one fifth of municipalities are too small to efficiently provide the most basic municipal services (Fritzen, 2000)

Decentralization involves major expenditure responsibilities being transferred to sub-national governments but there are few high-revenue taxes that can be assigned to them without creating national economic distortions. Intergovernmental fiscal transfer systems are therefore ‘structural’ components of decentralization. Poorly designed fiscal decentralization and intergovernmental fiscal systems have been major stumbling blocks to successful decentralization in the Europe and CIS region. Political and administrative decentralization are often not matched by sufficient fiscal decentralization due to a variety of reasons, often of a political nature. Irrespective of their level of revenue autonomy, most local governments in the region have very limited revenue-raising capacities due to poverty and limited economic activity, thus making them highly dependent on central government subsidies. But the central government transfer system is often complex, unstable and unpredictable (Fritzen, 2000)

In Russia for instance, the measurement of expenditure needs is based on as many as 50 indicators, making it excessively complicated and non-transparent. It is typical of many countries of the region that the bulk of the transfer is either subject to resource availability in the annual budget or has a tendency not to be implemented as budgeted, leading to the

common occurrence of ‘unfunded mandates’ resulting in serious conflicts between the central and local authorities and sharp deteriorations in the quality of public service delivery (UNDP, 2008).

The design of decentralization strategies is not the exclusive responsibility of central government. It is also that of the municipalities themselves. However, decentralization is often seen as freeing the central government of certain responsibilities and not as a common effort between the central and local level to improve the delivery of public services. Poorly organized and represented municipalities have often not been able to actively or effectively participate in the strategy formulation process, act as a check on government and help avoid painful mistakes. Limited capacity, absence of leadership and lack of consensus among local governments on the desirability of decentralization (the small and poor municipalities have often been strong opponents of decentralization due to their particular lack of resources and capacities) have contributed to this situation (Fritzen, 2000).

Apart from that the other challenges include that of Local individual and organisational capacities to assume the devolved responsibilities. A condition for successful decentralization is that the local governments possess the capacity required to effectively carry out their assigned responsibilities. Insufficient local capacity has been a persistent issue in the implementation of decentralization in the region and it has not been adequately addressed by the considerable resources invested by the donor community for capacity development. The main commonly advanced issues have been the following (Campos and Hellman, 2005)

- i. Absence of a strategic framework for capacity development of local government, or non compliance with the existing framework;

- ii. Donor-driven capacity development activities, as national and local governments have lacked the capacity to articulate their needs;
- iii. Inadequate coordination of capacity development activities between donors and national partners, as well as among donors;
- iv. Prevalence of ad-hoc capacity development activities which are rarely related to the objectives of reform strategies or concrete phases of implementation of the decentralization process;
- v. Lack of systemic approach to capacity development and inability to go beyond training of human resources.

However, beyond the above, the very form of capacity development assistance provided to local governments is increasingly questioned. The traditional approach has been to develop capacity through training and technical assistance before transferring public service delivery responsibilities. However, it is now recognized that it is difficult to expect local governments to change behaviours and improve performance solely on training and supply-driven technical assistance. Experience suggests that, for instance, training does very little for leadership, citizens' participation and accountability (Campos, and Hellman 2005).

Empirical evidence speaks to the fact that often conventional training did not result in changed workplace performance. This could be attributed to: (i) insufficient participant understanding of how to apply learning in the workplace; (ii) inadequate incentives or resources for implementation of new knowledge and skills; (iii) inadequate targeting of learning to organizational needs. Making the leap from individual learning to workplace performance and organizational and development effectiveness requires both good

training design and an appropriate organizational and institutional context in which to apply new knowledge and skills (Campos, and Hellman 2005).

Rather than plan large up-front investments in training as a prerequisite for devolution of responsibility, as has been the case in many countries of the Europe and CIS region, it is acknowledged that greater focus should be placed on strengthening organizational capacity of local government units and deploying additional methods of knowledge and skills transfer. There is growing appreciation of the fact that capacity development is more effective through 'learning by doing' than through 'listening' to trainers. There is therefore an emerging consensus that decentralization can, in itself, be the best way to build local capacity through learning by doing. This is why decentralization should take place gradually with the initial devolution of a few selected responsibilities and the progressive broadening and deepening of decentralization as local capacities are built. It is argued that the citizen oversight made possible by decentralization can actually be an important incentive to actively improve capacity (UNDP, 2008).

The issue of local capacities is very much linked to the issue of public administration and civil service reform. As local government staff is composed of civil servants in most of the countries of the region, without a reform of the national civil service it is difficult for local governments to attract and retain high quality staff and to ensure their professional development (low salary levels, lack of merit-based promotion systems and human resources management policy). The absence of a strategic approach to staff capacity development contributes to the ineffectiveness of capacity development activities. Last but not least, the issue of political appointments of municipal staff should not be underestimated. In Albania for instance there is an almost 'systemic' turnover of staff after each municipal election (ibid).

Municipal fragmentation the challenge for Europe and CIS countries is to find stable structures of government that are both politically acceptable and are also able to promote efficient and effective provision of services at the local level. The size of the local governments in the Europe and CIS region varies. Countries such as Bosnia and Herzegovina, the Czech Republic, Hungary, Armenia, Macedonia and Tajikistan have very small local governments that do not have the sufficient scale and/or lack capacities to manage efficiently the functions assigned to them. Administrative and territorial reform aiming at municipal consolidation has taken place in some countries such as Macedonia and Armenia. However, the scope of such reforms has been limited for political reasons and the problems related to municipal fragmentation persist. For instance, despite administrative and territorial reform, Armenia currently still has 925 Communities (local government bodies), more than half have less than 1000 residents, making it impossible for them to achieve the economies of scale necessary to deliver even the limited number of services that they have been assigned (Campos, and Hellman 2005).

For political reasons the consolidation of the local governments is often not the solution and an asymmetric devolution of responsibilities, inter-municipal cooperation (such as in Hungary) or several municipalities outsourcing the production of services to one public or private commercial entity are viable alternatives. However, these alternatives with a few exceptions (Czech Republic, Hungary) have seldom been pursued in the Europe and CIS region. As regards inter-municipal cooperation and outsourcing, a major constraint has been the widespread absence of tradition and capacities (Stepan, 2002).

In addition to the above point the other challenge include participation, accountability and community empowerment the notion that decentralization leads to more efficient public service delivery rests on the premise that local governments can be held accountable by

citizens for their decisions and actions. Because of this, they should listen and be responsive to their needs and concerns. However, political capture by local elites and general local government unresponsiveness are common in the Europe and CIS region. These are all signs of the remaining authoritarian-era legacy where the institution and political culture favoured such behaviour and worked against accountability (UNDP, 2008).

A strong system of local participation and accountability depends on the actions of local politicians to “supply” adequate mechanisms for community participation and accountability. It also depends on the actions of civil society, especially non-governmental organizations and independent media to “demand” more participation and accountability. In most of the countries in the region local politicians are either reluctant or do not know how to establish a constructive dialogue with citizens, NGOs and the private sector. Also, the process of community empowerment is very slow and only few countries can claim to have the kind of media and vibrant civil society that is necessary for the proper functioning of local democracy. There are many reasons for this situation, including limited awareness of citizens about their role in a decentralized context and their limited capacity to organise to make their voices heard. Without improvements in the mechanisms and institutions supporting accountability in the countries of the region where they are weak, the extent to which decentralization is meaningful and desirable will be ambiguous (Stepan, 2002).

Finally Burden of diseases creates a new threat to decentralization by devolution, globally the burden of disease was still very high in 1990s and it was estimated that  $1.4 \times 10^9$  Disability Adjusted Life Years were lost annually (Murray and Lopez, 1997). There was a very wide geographical variation of Burden of diseases across countries. Sub-Saharan

Africa, where there was less than nine per cent of the world population, had about 21 per cent of Burden of diseases.

Narrowing to national wide the following challenges are so numerous that impede the process of decentralization by devolution in Tanzania the first one being it fosters local loyalty to regional identities than the national identity, and this encourage more autonomy from the central government and even a territorial secession in multi-ethnic and multi-religious societies, particularly in Africa. This puts the national integrity itself at risk. Local elites may manipulate newly created autonomy for seeking their narrow personal benefits at the cost of general population who are in dare need have improved livelihood (Fumihiko, 2001).

The practice by central and sector ministries to govern by directive. Central Government (CG) directives, instructing LGAs to perform certain activities with their own decentralised funds, ignore the LGAs planning, responsiveness and commitments towards their population, and directly violates the principles of autonomy and D by D. LGA representatives strongly expressed their frustration with these CG directives. It is indicative of non-adherence by the CG to the D by D strategy and is a major threat to the success of the local government reforms (URT, 2008).

There is a cry for information on programmes and processes, as well as for official documents, like laws and policies, in readable Kiswahili. Local government reform programme II which is decentralization by devolution should be designed to look comprehensive (IEC) strategy Information, Education and Communication to ensure that relevant information and documentation reaches the population (URT, 2008).

Applying D by D, resulting in highly autonomous LGAs, puts high demands on leadership of the councils. It requires a standard of strategic leadership which is not yet commonly encountered at LGA level. LGRP II (D by D) envisages a new kind of leadership, which strives towards LGA development in a holistic way, making maximum use of existing potential in terms of human, financial and physical resources(URT, 2008).

Power relationship between the Council Director, District Commissioner and Council Chairperson, and more broadly into the relations between the executive, the councillors and the public (URT, 2008). Various sources, including LGAs themselves, point out a limited capacity in finance, human resources, systems and logistics. This concerns the number and quality of staff as well as working conditions. It is acknowledged that capacity is limited, but at the same time that LGA capacity is not an obstacle to D by D and does not justify hesitation to give autonomy to the LGAs (URT, 2008).

Lack of common vision to the policy decentralization by devolution and existence of non D by D policy and legislative framework, on many areas the legislative bottlenecks affect the operation within health service delivery. Despite of implementation of LGRP still there bottlenecks on implementation of decentralization by devolution on public. Unproportional distributions of sources of revenue between Central and Local Government, though it is a fundamental principle of resource allocation that resources follow functions (URT, 2008). Moreover the allocation of resources between Central and Local Government is made in contravention of this basic principle in the sense that allocation of resources between Central and Local Government is unproportionally aligned with functions as evidenced in 2008/09 budget where the share of the LGA's budget was only twenty percent (20%) of the total government budget (URT, 2002).

Inadequate mobilization of own source revenues like property rates and others which are necessary to co-finance health services, enhance a locative efficiency and strengthen local governance accountability. This challenge the provision of health services despite of articulated formula base disbursement mechanism to all local government but mostly the grants are distributed without a clear formula (URT, 2002).

Another challenge is empowerment of community although introduction of the devolution process to LGAs ascertained the first step of all the stakeholders to empower communities, those communities involved in the introduction of the devolution process do not necessarily realize community priorities in a tangible and sustainable manner. One reason could be that the devolution process does not motivate the stakeholders to learn out of their experiences from a long term perspective (IDCJ, 2009).

On other hand sustainability of community initiatives or projects, whether the process becomes sustainable and self-sustained largely hinges on the community motivation to make their initiatives growing or projects successful and enjoy sense of achievement in the post roll out stage. However in reality, communities are not necessarily motivated in that way. Some causes are conceivable. First, community projects not designed on the basis of adequate understanding of the community from its functional point of view. Without knowing how each stakeholder and local organization functions in their local context, they are not able to design a project in an operational manner. Second, even if they well versed with the functional aspect of communities, the community project will not sustainably implemented without their reasons or justification why they want and need to make a commitment (IDCJ, 2009).

Shortage of human resources in many local government authorities particularly in remote areas result into lowest health personnel coverage per population in the world. For

example, there are 0.4 physicians and 2.8 nurses and midwives per 10,000 people. This is well below the corresponding average figures of 2.8 physicians and 6.7 nursing and midwifery personnel for all of the world's low income countries (GHI, 2011). However the country is facing a new threats of HIV/AIDS epidemic, communicable diseases such as tuberculosis (TB), malaria, respiratory infections, and diarrhoeal diseases. Malaria an estimated 1.4 million people already infected with HIV, and each year an estimated 100,000 are newly infected and 86,000 Tanzanians die, this results in disrupted family structures and an estimated 1.3 million children orphaned or vulnerable (GHI, 2011).

Generally the countries made a milestone progress in health service delivery but there is in need of bolded action to meet the Mugs goal and that of MKUKUTA. Nevertheless, currently Tanzania ranks 15<sup>th</sup> out of the 22 countries with the highest TB burden and it remain the leading cause of morbidity and mortality among people living with HIV (GHI, 2011).

### **2.3.4 Reasons for challenges of D by D Worldwide**

Globally, reasons for the challenges of decentralization by devolution on health service delivery have never been apparent for many years, depending on socioeconomic, culturally, geographically and politically. One of the reasons for challenges faced provision of health services is increases of Health expenditure in all European countries, at a faster rate than economic growth. In 2008, EU countries spend an average of 8.3% of GDP on health, up from 7.3% in 1998. However, the recent economic downturn will significantly add pressure to health service budgets, and many countries are decreasing their public expenditure. This driven by political/ideological and imperatives in order to reduce budget deficits (David, 2008). However, the global health revolution abruptly reached its terminus in 2008 after global economic crises changed the political,

diplomatic, and governance contexts of global health. As if the crisis riddled present was not bad enough, longer term projections of political, economic, demographic, and ecological trends. This raise concerns that global health confronts challenges it could not have met even without the damage done by the crises of 2008 (David, 2008). World Health Organization member countries embraced the concept of universal coverage as early as 2005, few low-income countries have not yet achieved the objective. This is mainly due to numerous barriers that hamper access to needed health services namely geographical access, availability, affordability, and acceptability. These barriers have impacted the decentralization of service delivery on health sector on many countries (Bart, *et al.*, 2011).

Climate change is not new, nor is global health a stranger to analyzing the potential impact of climate change on health. WHO for years, examined health consequences that global warming could stimulate, such as the spread of vector borne diseases. Climate change became more ominous in 2008 because evidence began to mount that the effects of climate change were happening faster than anticipated. The most dramatic evidence came from research on the rate of melting sea ice in the northern polar region (David, 2008). These accelerated effects, and their projected trajectories, underscored the need to mitigate the impact of climate change and not focus exclusively on reducing greenhouse gas emissions (David, 2008).

Global Energy Crisis, Oil prices increased during 2007 and even more sharply in the first half of 2008. In July 2008, the price for a barrel of oil reached a peak of U.S.\$ 147.35. Even more abruptly, oil prices collapsed to around U.S.\$ 40 per barrel by December 2008, largely because of the global economic crisis. Although the global energy crisis came and went during 2008, it had negative repercussions for global health. In terms of direct

impact, the increase in oil prices put some countries under macroeconomic stress, producing energy shortages that contributed to negative health outcomes, particularly among vulnerable populations (David, 2008).

Global Food Crisis skyrocketing oil prices made petroleum-based inputs into food production like fertilizer and distribution gasoline for transportation dramatically increase, which helped force food prices higher around the world. Other factors also played a role in sharply rising food prices, including increasing demand for food and damage to food production caused by droughts and other weather related events. Higher prices created problems with affordable access to food in many countries, some of which experienced civil unrest because of escalating prices. The actual and projected impacts of the global food crisis are disturbing. The UN High-Level Task Force on the Global Food Crisis (UN Food Crisis Task Force) stated in July 2008 that the rise in global food prices. WHO indicated that the global food crisis created immediate and long term threats of malnutrition, which deepen poverty; increase child and maternal morbidity and mortality; make people more vulnerable to communicable diseases; impair mental development, learning ability, and work productivity; and increase prevalence of chronic diseases (David, 2008).

Apart from above reason the other reason for challenges face health service delivery are catastrophic event, like flood and lightning storms. This have human health impacts of extreme storms go beyond direct injury and death to indirect effects such as carbon monoxide poisoning from portable electric generators Also hurricanes, increase stomach and intestinal illness among evacuees, and mental health impacts such as depression and post traumatic stress disorder. Heavy rains can lead to flooding, which can cause health impacts including direct injuries as well as increased incidence of waterborne diseases due

to pathogens such as *Cryptosporidium* and *Giardia*. Downpours can trigger sewage overflows, contaminating drinking water, and endangering beachgoers (Esohe, 2012).

Tanzania like most of the developing countries have been affected by global forces that ultimately reasons for challenges facing health service delivery regardless of the role of decentralization on service delivery the first and foremost reason is the rapid population growth. The trajectories within the population create threats on health provision and rise many challenges. Moreover other reasons include socio-cultural changes, HIV/AIDS pandemic and poor socio- economic trends, early pregnancies, child abuse, child neglect and family rejection, alcohol, drug abuse, child labour, increasing levels of destitution, commercial sex (prostitution), cases of sexual assault, which are exacerbated by poverty (URT,2008).

Other increasing social problems include family disintegration, marriage breakages, number of street children, number of orphans, vulnerable children, widows/widowers, elderly (aging), human trafficking especially children, increasing number of children in conflict with the law, child delinquency and single parenting (URT,2008).

In Tanzania the Retrenchment Policy coupled by an employment freeze implemented from 1993 until 1999 led to a sharp decline in the health workforce even as the disease burden increased, and consequently, present human resource crisis in the health sector. During this period, 23,474 health staff graduated from different training institutions but there were no apparent effort to employ them. Another setback was the decision made which had a negative impact, for example in the 1990s civil service reform undertaken resulted in position of budget ceiling and downsizing of the workforce. The public health sector suffered extensively from loss of experienced and skilled health workers. Moreover, the sector faced the problem of weak planning and forecasting of human

resource requirements. There were also problems of inadequate involvement of the private sector in human resource planning (URT, 2008).

Another major contributor to the crisis is the brain drain within and outside the country, however, the magnitude of the problem not well understood and there is therefore an urgent need to put in place a mechanism to monitor health professionals' movement within and outside the country (URT, 2008).

An important reason that has contributed to increase challenges in the provision of health service delivery is the human resource shortage situation is the chronic under funding of the health sector. The Abuja declaration recommends allocation of 15% of national budget to health sector. In Tanzania health sector has been receiving as follows; in 2001/02 it was 11%, in 2003/04 the share dropped to 9.7% and in 2004/05 there was an increase up to 10.1% while in 2005/06 it was 11.6% and in 2006/07 it dropped to 10.6% of national budget. The fluctuations affect allocations to human resources in particular the recruitment, incentives, retention, and capacity building (URT, 2008).

Another fact, which added to the shortage, is the government policy of 2002, which does not allow standard seven leavers to employ in the government facilities. Moreover, scheme of services does not allow employment of lower level Social Welfare cadres including the certificate and diploma level. These cadres trained at the Institute of Social Work Dar es Salaam but in most cases employed by the private sector (URT, 2008).

The shortage of personnel and other low cadre workers within health service this attributed by, low output of qualified staff, mal-distribution, poor remuneration, poor infrastructure, and lack of attractive retention scheme. In 2006, there were 5,795 health facilities in the country. These facilities are bound to increase with the implementation of

Primary Health Service. Development Plan up to 13,039 by 2017. Given the facilities increase, automatically the demand for more human resource will be inevitable and therefore the need to increase the training and absorption of skilled health and social welfare workforce is necessary (URT, 2008).

### **2.3.5 Research gap**

Despite having many studies on both developed and developing countries on challenges of decentralization by devolution on health service delivery, many studied decentralization in a holistic way without recast to specific approaches to decentralization like Deconcentration, delegation, devolution, and privatization, while other studied on impact on service delivery. WHO, (2000) conducted a study on India and found that Decentralization of health services is regarded as the most important force in improving efficiency as well as equity and responding to local health conditions and demands hence improved the services delivery. Moreover Masoi and Norman, (2009) pinpointed the similar precedent. Decentralization by devolution in Tanzania: Reflections on community involvement in the planning process in Kizota Ward in Dodoma, this study focused specific dimension which is the involvement of people on planning process but not rather investigate major challenges that hamper community participation. Mugga, (2009) found that recruiting workers under decentralized arrangement may be difficult and expensive hence it not leads to improvements health services deliverance particularly in rural areas. On other hand Godfrey, *et al.*,(2007) conducted a research in Lushoto and Muhenza district and found out that charges drive poor pregnant women to consult traditional birth attendant or decided to deliver at home while claimed that the government policy require them free of charge, under five years children exempted from charge. However, no important drugs hence children die because of malaria, participants contributed cost of fuel for ambulance in case of in need for referral and lack of essential laboratory services

for lower health facilities. From this juncture it, however, be clear that many studies studied decentralization by devolution, on capacity utilization services output. Others appraise the impact of decentralization on livelihood of people without clearly examining the challenges that face decentralization by devolution on health service delivery. Thus the research optimizes that gap to investigate the Challenges of Decentralization by devolution on health service delivery at Dodoma urban district.

### **2.3.6 Conceptual framework**

This research paper is concerned about roles and challenges of decentralization by devolution on public health delivery at Dodoma urban district: A case of Dodoma urban district. The concept of decentralization by devolution encompasses integration of various components like Decentralisation by devolution, delegation devolution, and privatization. Decentralization by devolution entailed Local government fiscally empowered and made accountable, Human resource empowerment of local government, Legal framework for decentralisation by devolution and Principles of good governance.

The independent variables for this study are challenges of decentralization by devolution such as Political will, institutional design, weak policy capacity, high need for training, municipal fragmentation, participation and accountability ,burden of diseases, lack of clear vision among actors, power and leadership, corruption resources allocation and sustainability of community initiative project.

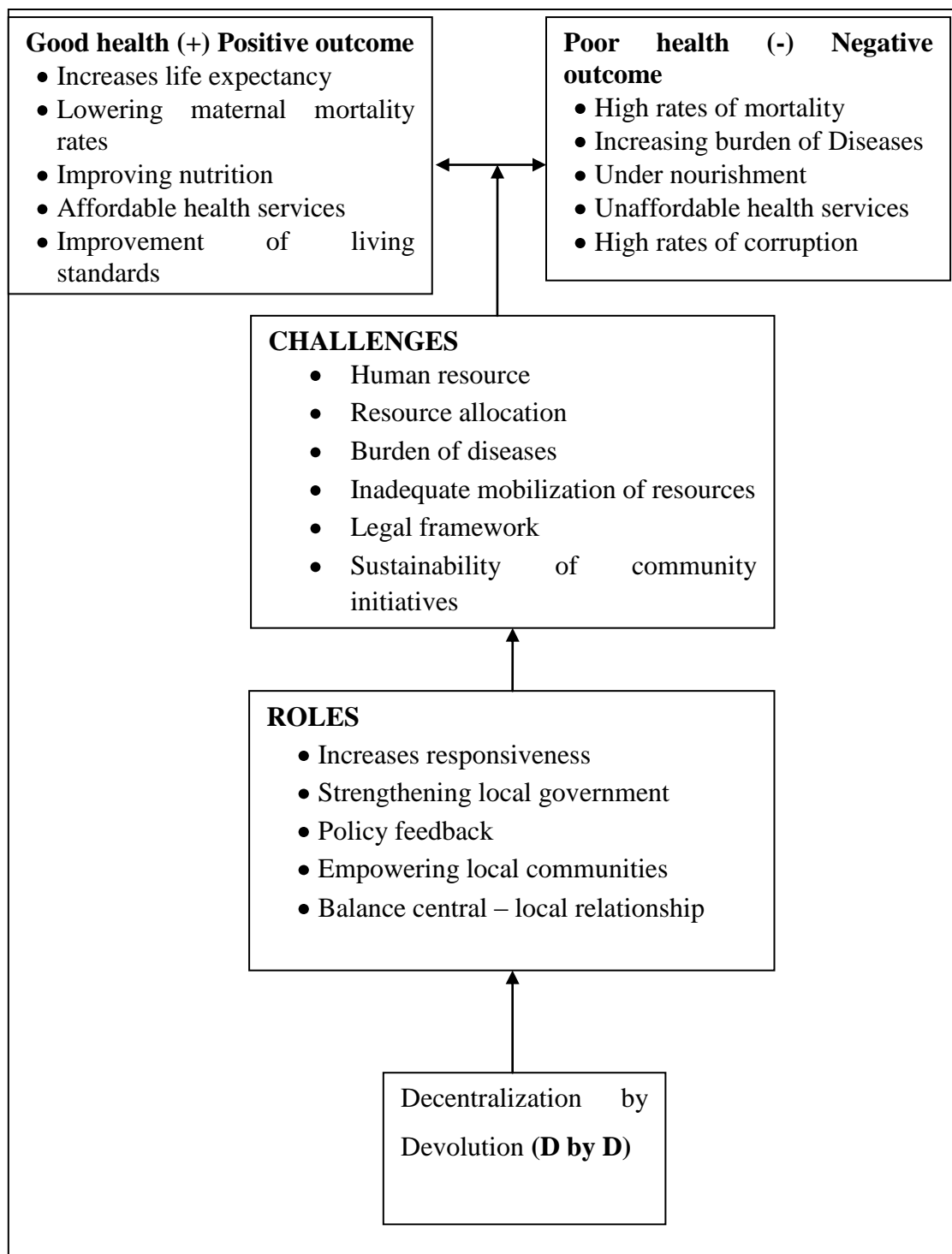
While intervened variables include Food crisis, Structural Adjustment Policy and Economic Recession, Global climatic change, Retrenchment Schemes, Rapid Population Growth, Political Conflicts natural hazards and physical barriers

The dependent variable is the public services delivery measured by facility utilization, efficiency, and cost effectiveness, declined of mortality rates, prevalence rates, and outpatient attendance per capita.

Delivery of public health services depended much on the challenges that face decentralization by devolution like political will whereby the existing country is able to open for decentralization and politically consciousness that aimed to address challenges that encounter decentralization by devolution. Institutional design the absence of capacity and mechanisms to monitor the implementation of reform has prevented the timely identification of emerging issues and the adoption of corrective actions. Weak policy capacity to implement decentralization raises other challenges to the provisional of health service delivery. High need for training normally hinder the provisional of health services to many places in the world. Municipal fragmentation lack stable structures of government that are both politically acceptable and are also able to promote efficient and effective provision of services at the local level. Participation and accountability of the local citizens into policy formulation and implementation shy aside people from being active participant and rather passive recipient. Burden of diseases and lack of clear vision among actors, Power and leadership, corruption, Resources allocation sustainability of community initiative project together raise a serious challenge on the service delivery.

Both independent and dependent variables constitute to the Efficiency value theory of decentralization where by public choices of decentralization is understood as a social welfare because the people are the hub for decentralization, thus the challenges of decentralization by devolution would ultimately depended on the either its existence result into poor service delivery while once overcome the health service delivery would be improved, but the intervene variables will continuous trigger the new challenges

**Figure 1: Conceptual framework of the study**



Source: Documentary Review, 2013

### **2.3.7 Conclusion**

Chapter two presents literature review drawn from different studies, the first part include theoretical review encompasses the definition of the key terms, like roles, challenge, decentralization by revolution, public, health, service, and service delivery, theories explain challenges of decentralization on public health service delivery, include Efficiency Value Theory, Governance Value Theory, Organization Theory, A Sequential Theory In addition theories explain the roles of decentralization by devolution on public health service delivery, theories for reasons for the challenges of decentralization on public health service delivery like Principle Agent Theory, Top- Down Theory, Vicious Cycle of Poverty, Fiscal Decentralization Theory, Participatory Liberal Theory, Mismatch Between Authority and Responsibility Theory, and Construction Theory on public health and Lastly Conceptual Framework of the study.

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 Overview

This chapter presets the methodology that employed during research process. The chapter is divided into six parts namely research design, study area and location, data collection tools and techniques, sampling methods, data processing, analysis, research ethics and data presentation. The last part explains how data be ensured to be valid and reliable.

#### 3.2.1 Study Area and Location

Dodoma region located at  $6^{\circ}10'23''\text{S}$  and  $35^{\circ}44'31''\text{E}$  Coordinates:  $6^{\circ}10'23''\text{S}$   $35^{\circ}44'31''\text{E}$ , in the centre of the country, the town is 486 kilometres (302 miles). West of the former capital at Salaam. It covers an area of 2,669 square kilometres (1,031 sq miles) of which 625 square kilometres (241 sq miles) are urbanized (Andreas, *et al.*, 2009) The region comprise of five districts namely Dodoma rural district Kondoa district, Mpwapwa district Kongwa district and Bahi district. The scope of this study covered by one main objective that to examine the role and challenge of decentralization by devolution on health service delivery at Dodoma urban district. The upcountry districts excluded purposely in the sample given due to the limitation in time and finance. Meanwhile Dodoma is the capital city of Tanzania and offer a long history of decentralization by devolution in Tanzania Hence this will serve a researcher to minimize the financial costs and utilization of human resources and physical resources.

#### 3.2.2 Population

The region has total population of, 1,735,000 people male are 818,042, which is equal 48.5 percent and female are 875,599 equal to 51.5 percent (Andreas *et al.*, 2009). The sole

reason why a study done at Dodoma is the fact that Dodoma has oldest history of decentralization in Tanzania. Since the early phases of decentralization, the policy started implemented in Dodoma since 1972 when the capital city shifted to Dodoma from Dar es Salam. But regardless for this reasons but health service delivery are still pursuit like general shortages of essential drugs, long time spent by patient to receive services, lack of equipment for health workers, and financial constrains.

### **3.2.3 Climate**

Dodoma region located in the centre of Tanzania exposed to a semi-arid climate at an altitude of 1125 meters above sea level. Dodoma features a semi-arid climate with relatively warm temperatures throughout the year. While average highs are somewhat consistent throughout the year, average lows dip to 13 °C (55.4 °F) in July. Dodoma averages 570 mm of precipitation per year, the bulk of which occurs during its wet season between November and April. The remainder of the year comprises the city's dry season (Andreas *et al.*, 2009)

### **3.2.4 Economic context**

The region is almost entirely dependent on agriculture and livestock production, which are locally practices largely at household level. There is small scale processing of agricultural and livestock products. Agriculture characterized by low productivity resulting from low and erratic rainfall, high evapo-transpiration, and low moisture holding capacity compounded by poor farming practices and overstocking makes region susceptible to extensive soil erosion. Natural resources include forestry, wildlife beekeeping, and mining. At urbanized areas the most practiced economic activities involves industries, commerce and civil employment (Andreas *et al.*, 2009)

### **3.2.5 Socio- political context**

Dodoma has been Tanzania's capital since the 1970s and is the seat of the Union Parliament. Being the third largest city in Tanzania, it has about 400'000 inhabitants and faces a high yearly population growth rate of 3.4%. Dodoma Region comprises an area of 70 km<sup>2</sup> and is divided into 17 urban and 13 rural wards (Chaligha, 2008)

### **3.3 Research Design and methods**

This study used cross-sectional survey design. This is because cross-sectional helps to save time by conducting a research compare to longitudinal research design (Saunders *et al.*, 2009).The study employed both qualitative and quantitative research to assess the challenges of decentralization by devolution in health service delivery at Dodoma urban district. To comply with its objective the study employed use of interview, questionnaire, and participatory observation to enable a researcher to diversify instrument for data collection in broad spectrum and uncertain that may encounter during data collection

### **3.4 Sampling techniques and procedures**

The research will employ the use of purposive sampling technique followed by simple random sampling because Dodoma has been oldest city with long history of decentralization by devolution in Tanzania. However regardless of long history in Dodoma health service delivery is not conversing. Decentralization was been implemented since 1972 shifted of capital city from Dares salaam to Dodoma. Even the PMO-RALGs located at Dodoma (URT, 2008). Purposive sampling and simple random sampling will enable researcher to targets a group of people believed to be reliable to the study (Kothari, 2003).

Again the purposive sampling technique employed to get key personal to provide their views on Decentralization by Devolution on Public Health Service Delivery at Dodoma urban District.

### 3.5 Sample size and Sampling frame

Kothari, (2005) used this formula to determine sample size  $N = \frac{Z^2 p q}{d^2}$

Where by

n= sample size

Z = Standard normal deviation which is 1.96 (2 standard deviation)

P =Proportion of the target population estimate

q= (1-p)

d<sup>2</sup> = degree of accuracy which is 0.05

From the given data the total population of Dodoma by year (2002) was 1,735,000

Population of Dodoma urban district by year 2002 was 324,347

To calculate the sample size

$$n = \frac{1.96^2 \times .0.186 \times 0.81}{.05^2}$$

$$n = \frac{3.8416 \times 0.15066}{.0025}$$

$$n = \frac{0.57877546}{.0025}$$

$$N = 231.51$$

In order to obtain 100 sample

40% of 231 =  $40/100 \times 231 = 92$

N= 92

Thus number of sample obtained is 231 people. This sample size is very huge to undertake because of the time limit for study, secondly financially expensive and needs huge human resources that will not solely ascribed by a researcher. Therefore the study will use the 40 % of the total sample (n) 231  $40/100 \times 231=92\%$  which is equal 100 sample size. Therefore 100 respondents selected purposively where each unity selected randomly according to their merits towards study.

**Table 1**Distribution of sample size

<b>Sampling unit</b>	<b>Number of people</b>	<b>Total</b>
District Medical Officer	1	1
Health workers	32	32
Ward Executive officers	5	5
MSD representative	1	1
NHIF leader	1	1
Household member	60	60
<b>Total</b>	<b>100</b>	<b>100</b>

### 3.6 Sampling unit

The sampling unit comprises the following, District Executive Director, Division officers, health workers, medical store department representatives, Patients, NHIF personnel, and Household members.

### 3.7 Data collection techniques and procedures

Data collection for this study will depend on primary and secondary sources

### **3.7.1 Primary Source of data**

Primary data sources are those, which are collected afresh and for the first time, and thus happen to be original in character. This means original data that been collected specifically for the purpose in mind. It means someone collected the data from the original source first hand (Kothari, 2005).

#### **(a) Questionnaire**

The questionnaires will be administered local communities, the questionnaire will be both closed ended and open ended to insure more reliability and validity of the respondent's. This method enables the researcher to administer easily, massive data collection, inexpensive and reduce anonymity during data collection compare to other data collection techniques (Kothari, 2003).

#### **(b) Structured Interview**

The Structured interview will be interviewed to the key informants like district executive director, division officers, health workers, medical store department representatives, household members and NHIF leaders, it will enables a researcher to capture information that failed to be collected through questionnaires to other respondents who are illiterate. The structured interview increases consistency by interviewing respondents in a structured way and avoiding repetition of conversation and enable a researcher to clarify the purpose of research while able to encourage respondent's participation (Adam, and Kamuzora, 2008).

#### **(c) Participatory observation**

The research will also employs participatory observation method for data collection where by a researcher will observe by making himself more or less a member of the group so

that to experience what the member of the group experience. This method will supplement other method of data collection used to eliminate subjective bias and relates more to what currently happening in the social context (Kothari, 2003).

### **3.7.2 Secondary data**

These data are already collected for other people which passed through statistical processing such include different government circular, policy manifesto, constitution and LGRPs I and LGRPs II, SAPs, MKUKUTA, Demographic health survey, magazines journals unpublished government document and internets sources such as encyclopaedia and Encarta.

### **3.8 Data Processing**

Data processing involves coding of data entering of data to the computer package for social science statistical package and then processed by using (SPSS-version 16) to convert data into usable information. It involves recording, analyzing, sorting, summarizing, calculating, disseminating, and storing data. The qualitative data be processed using explanations and ranking

### **3.9 Data Presentation**

Data will be presented using graphs, pictorials and tables so that to make data statistically significance and interpretable easily and make the reader to understand instantly.

### **3.10 Data analysis**

For specific objectives to examine role and challenges of decentralization by devolution on public health service delivery the use of both descriptive and inferential statistical method were use. For descriptive statistics the use of percent, mean, frequencies and ratios will be employed to analyze data, while for inferential the research will use multiple

linear regression analysis with the aid of Social sciences Statistical package (SPSS Version 16) to analyze data obtained.

### **3.11 Ethical issues**

The study followed ethical approval from university of Dodoma the researcher will explain the purpose of study in each session in order to create awareness to the respondents in order to assure them that the findings be used for academic purposes only. There will be no any information that will be used for unscrupulous issues by maintain the discretion of information rendered by informants for all period of research.

### **3.12 Validity and reliability of data**

Validity refers to the degree to which the instrument measures what it is suppose to measure (Mark *et al.*, 2009).The researcher give the questionnaire to the respondents from Dodoma urban district to verify and validate the questions and objective. The reviewer's supported the assertion that the component of questionnaires reflected the investigation of roles and challenges of Decentralization on PHSD at Dodoma urban district. A pre test conducted to obtain information for improving the questionnaires and assessing feasibility of the study.

### **3.13 Limitation of the study**

The study encounter following limitation like availability of important information from government officials vastness of the area made data collection to be more tedious work decentralization by devolution not well enshrined into constitution hence it contradict with other policy issues and harmonization of the overall is still curtailed .Lastly the programme is reads in English and hinder understanding amongst majority. To avoid the availability of information on important government official the researcher will clarify the aim of research and consider all ethical issues involved in research and disclaimer on

confidentialities regarding their responses this, measures like the use of questionnaire and structured interview and survey, interpretation and testing of all tools considered to get actual information

### **3.14 Conclusion**

This chapter presented research methodology applied in the study which is cross- section survey done at Dodoma urban district to the total population of 1,735,000 at Dodoma region which is the semi-arid climate located at latitude of 1125 meters. The region dependent on agriculture and livestock production being a capital city since 1970 .The study used purposive sampling technique and a sample size of 100 people employed. Data collected through interview and questionnaires. Data processed using SPSS- version 16, Analysis and presentation validity and reliability and finally conclusion itself.

## **CHAPTER FOUR**

### **RESULTS, DATA ANALYSIS AND DISCUSSION**

#### **4.1 Introduction**

This chapter presents data analysis and discussion of the findings. The statistical Package for Social Sciences for Social sciences used for analyzing the data .The findings answer the general objective of the study, which was roles, and challenges of decentralization by devolution on Health service delivery in Dodoma region. The specific objectives were; (i) to examine the role of Decentralization by Devolution in health service delivery Dodoma urban district; (ii) to analyze challenges of decentralization by devolution in health service delivery in Dodoma rural district; (iii) measures to overcome the challenges of D-by-D on PHSD

#### **4.2 Demographic characteristics of the Respondents**

##### **4.2.1 Sex**

It found that, out of 100 respondents 57 respondents were women, which constitutes 57% and 43 respondents, were female .This means that there was a large number of female respondents at Dodoma Urban District compared to men. This is due to several reasons that most women are staying at home while husbands are susceptible to mobility for daily bread winner activities such as selling charcoal, agriculture, and petty business, secondly most employed far from their homestead while others transferred to remote areas where it's unsupported to live with their families. Table 1 bellow shows the gender distribution of the respondents.

**Table 2: Sex distribution of the respondents**

<b>Sex</b>	<b>Frequency n = 100</b>	<b>Respondents (%)</b>
Female	57	57
Male	43	43

**Source: Fieldworks Survey, 2013**

#### **4.2.2 Age-Group of the Respondents**

Age is very important in determining policy response and implementation in any human communities and for planning activities in each and every organization. The age distributions of respondents were presented in six age- groups. The result showed that, 15 (15%) of the respondents were in age group between 18 and 30, and 50 (50%) of the respondents were in the age- group between and 40. In addition, 20 (20%) of the respondents were in the age group between 41 and 50, and 15 (15%) of the respondents were in the age group between 51 and as shown in Table 2 below.

This showed that the majority of the respondents 50 ( 50%) were between 31 and 40 years which are actually prime age for explaining roles and challenges of decentralization by devolution on health service delivery and directly intervened or counterfeited with policy implementation on their daily lives. Also the findings showed that 20 (20%) of the respondents were between 41 and 50 and were heads of departments, experienced and aware of the policy of decentralization by devolution and some are key implementers in their sections. The last age – groups both constitute 15 (15%) each are 18 and 30 and 51 and 60 are young and older to whom intervention people whose policy intervene is intermediate to them but crucial for policy implementation.

**Table 3: Age Group of the Respondents**

<b>Age-Group</b>	<b>Frequency</b>	<b>Respondents (%)</b>
	<b>n = 100</b>	
18-30	15	15%
31-40	50	50%
41-50	20	20%
51-60	15	15%

**Source: Fieldwork Survey, 2013**

#### **4.2.3 Marital status of the respondents**

The research findings showed that 34 (34%) of the respondents were single and 57 (57%) of the respondents were married and 7 (7%) of the respondents were widows and 2 (2%) of the respondents were divorced. This indicated that the large number of respondents are married and have families thus they were directly clientele to health service delivery and proactive to policy of decentralization by devolution. Moreover the widows and divorced which constitutes 9 (9%) of respondents are interacted with the policy of health services delivery as they mostly lack income to afford medical treatments as shown in table 3.

**Table 4: Marital Status of the Respondents**

<b>Marital Status</b>	<b>Frequency</b>	<b>Respondents (%)</b>
	<b>n = 100</b>	
Single	34	34
Married	57	57
Widows	7	7
Divorced	2	2

**Source: Fieldwork Survey, 2013**

#### **4.2.4 Education Level of the Respondents**

The respondents were required to reveal their level of education. The findings shows that 37 (37%) of respondents in Dodoma Urban District were holding a Certificate of Primary School, 23 (23%) of respondents holding Ordinary Level Certificate, and 13 (13%) of

respondents holding Advanced Level Certificate, and 10 (10%) were Diploma holders, 12 (12%) of the respondents were bachelor degree holder and only 5 (5%) of respondents hold Master Degree. From table 1 below it can be concluded that the level of understanding regarding the policy of decentralization of health service delivery varied beside educational levels of the respondent and the language of the policy was a problem to majority of the lower cadre and household members.

**Table 5: Educational Level of the Respondents**

<b>Level of Education</b>	<b>Frequency</b>	<b>Respondents (%)</b>
	<b>n = 100</b>	
Primary Level	37	37
Ordinary Level	23	23
Advanced Level	13	13
Diploma Level	10	10
Degree Level	12	12
Master Level	5	5

Source, Fieldwork Survey 2013

#### **4.2.5 Occupation of the Respondents**

The findings showed that 1 (1%) respondent were District Medical Officer, 32(32%) Health workers, 5 (5%) Ward Executive offices, 1 (1%) Medical Store Department, 1 (1%) National Health Insurance Fund Representative and 60 (60%) are Household members. The findings showed that the large number 60 (60%) of respondents were household members who were clientele of the policy and the followed by 32% health workers who were the key policy implementers.

**Table 6: Occupation of the Respondents**

<b>Occupation</b>	<b>Frequency</b>	<b>Respondents</b>
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	<b>n = 100</b>	<b>(%)</b>
District Medical Officer	1	1
Health Workers	32	32
Ward Executive Officers	5	5
Medical Store Department Representative	1	1
National Health Insurance Fund	1	1
House Hold Member	60	60

**Source: Fieldwork Survey, 2013**

### **3.3 Objective One: Roles of D by D of PH D**

#### **4.3.1 Rates of awareness of D by D by key Respondents**

From the findings it was revealed that 25 (63%) of the Key respondents at Dodoma Urban District was aware on the roles of D by D regarding Public Health Service Delivery and it was introduced for sole reasons of increasing policy responsiveness, and provides policy feedback. While 15 (37%) of the Key respondents were unable to mention the roles of decentralization by devolution because most of them were not participated on seminar and training as their senior supervisor usually attended the seminars and workshops of decentralization by devolution on public health service delivery as it showed in Table No.6 below .

**Table 7: Awareness of the Key Respondents on the roles of D by D of PHSD**

<b>Response</b>	<b>Frequency</b>	<b>Respondents</b>
	<b>n = 40</b>	<b>(%)</b>
No	25	63%

Yes 15 37%

**Source: Fieldwork Survey, 2013**

Besides, the household member were also distributed questionnaire to measure their awareness of D by D on PHSD The findings showed that 55 (91%) of the respondents were not aware on the roles of decentralization by devolution (D by D) of public health service delivery simply because there was no involvement in policy formulation process. While 5 (9%) of household respondents was unaware on roles of D by D in PHSD. For instance a study by Massoi and Norman (2009) revealed that about half 52 (52%) and a third 35 (35%) of total interviewed respondents at Mtaa Kizota ward reported that the community involvement in preparing three years strategic plan was initiated with being involved and very few of them reported the community was participated respectively. Therefore the government should shift it paradigm of policy formulation from Top-down to Bottom-up approach to increases policy responsiveness to people and that tailor it to the local needs and this probed to the element of bottom up approach for effective policy implementation.

**Table 8: Awareness of the Household Respondents on the roles of D by D of PHSD**

<b>Response</b>	<b>Frequency</b>	<b>Respondents (%)</b>
	<b>n = 60</b>	
Yes	5	9
No	55	91

**Source: Fieldwork Survey, 2013**

Generally, from both key respondents and household members the study revealed that 70 (70%) of respondent was unaware about roles of D by D on PHSD at Dodoma Urban

District, meanwhile those aware on roles of D by D on PHSD was 30 (30%) of the respondents as shown in Table No.9 below

**Table 9: Awareness of the Respondents on the roles of D by D of PHSD**

<b>Response</b>	<b>Frequency</b> <b>n = 100</b>	<b>Respondents</b> <b>(%)</b>
Yes	30	30
No	70	70

**Source: Fieldwork Survey, 2013**

#### **4.3.2 Knowledge on roles of D by D by key Respondents**

In this area it intended to find out knowledge of respondents on roles of D by D in PHSD at Dodoma Urban District. The respondents were ask to mention down correctly roles of D by D on PHSD, and the results were 40 (40%) correctly mention down roles of D by D on PHSD, while 60 (60%) incorrectly mentioned down the roles of D by D in PHSD as showed in Table No. 10 below, this is because the policy is not well popularized to local community.

**Table 10 Knowledge on roles of D by D on PHSD**

<b>Responses</b>	<b>Frequency</b> <b>n = 100</b>	<b>Respondents</b> <b>(%)</b>
Correct	60	60
Incorrect	40	40

**Source: Fieldwork Survey, 2013**

#### **4.2.3 Effectiveness of D by D on PHSD**

Under this section the study wanted to capture if the respondents were able to assess the effectives of D by D on PHSD in Dodoma Urban District and the Likert Scale Weights

was used, and the common opinion of all respondents was 3 (three) that is undecided. The result implied that the respondents were of the opinion that they cannot understand whether D by D on PHSD was effective or not effective. The reasons of not understanding may be contributed by no participation and sensitization in planning and implementation of the D by D in addition there are many challenges facing D by D in LGAs level, as showed in Table 11: below

**Table 11: Effectiveness of D by D on PHSD**

**Likert Scale Weights**

<b>Weight</b>	<b>Frequency</b>	<b>Percent (%)</b>	<b>Total Weight</b>	<b>Average Weight</b>
5	Very effective	20	100	=3
4	Effective	10	40	
3	Undecided	25	75	
2	Not effective	30	60	
1	Not Very effective	15	15	
		<b>N=100</b>	<b>290</b>	

**Source: Fieldwork Survey, 2013**

**4.3.4 The application of roles of D by D on improving PHSD**

In this area the study aimed to find out applicability of the roles of D by D on PHSD at Dodoma Urban District. Table No 12 Below showed that 45 (45%) of the respondents viewed that D by D is applicable on PHSD at Dodoma Urban District, While the remained 55 (55%) of respondents reported that roles of D by D are not applicable in PHSD.

**Table 12: Applicability on roles of D by D on PHSD**

<b>Responses</b>	<b>Frequency</b>	<b>Respondents (%)</b>
	<b>n = 100</b>	

Yes	45	45
No	55	55

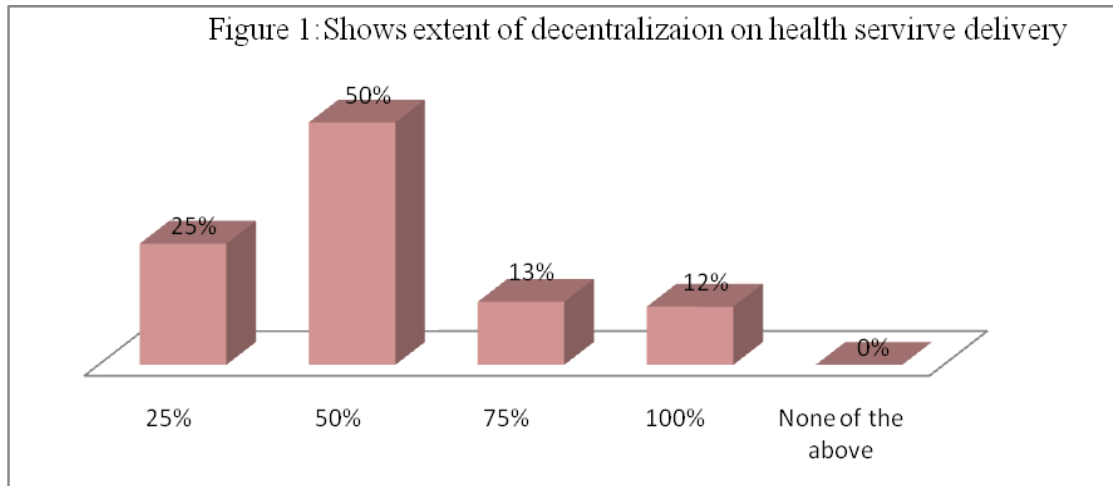
**Source: Fieldwork Survey, 2013**

#### **4.2.5 The extent of D by D on improving PHSD**

In this question the study intended to measure the extent of D by D on PHSD at Dodoma Urban District, as indicated in figure 2. Showed 50 (50%) of all respondents apprised that decentralization by devolution improved the health service delivery to 50% only, 25 (25%) respondents apprised that D by D improve health service delivery 25%, and ,13 (13%) of respondents apprised that decentralization by devolution improved health services delivery to 75%. While 12 respondents apprised decentralization by devolution improved health services delivery to 100%.

According to the interviewed conducted to the 40 key respondents 30 (75%) argued that if D by D was well planned and supported by the government the policy would improve health service delivery to 75% particularly in peri-urban areas where there are no private dispensaries. Many previous studies study decentralization by devolution on public health delivery with reference to Administrative Decentralization where by about 60% of all government employees are employed at local government that enable to improve service delivery (Mmari, 2005, URT, 2008)

**Figure 2: The extent of D by D on PHSD**



Source :Fieldsurvey 2013

#### 4.4.Objective Two: Types of Challenges by D by D on PHSD

In order to know the types challenges that face implementation of D by D on PHSD at Dodoma urban district the researcher distributed questionnaires to 100 respondents to identify the challenges that may encounter during the implementation of the policy. The findings revealed that 40 (40%) respondents rated Legal framework being the major challenge for local community from being free to make independent decision. While 30 (30%) of respondents also revealed that the central government failed to decentralize its financial capability to local government despite of formula based and poverty index criteria yet the process is compounded with frequent delays on financial distribution that impaired service delivery on varied health systems. As well, 25 (25%) of the respondents revealed that lack of essential drugs, reagents and health facilities, while only 5 (5%) of respondents pinpointed out local government structures being a challenge for implementation of decentralization by devolution on public health services delivery. Besides that similar findings were reported by (URT, 2009) indicated that D by D policy failed to strengthen Legislative framework and there are interruptions of devolution for HRM and financial management. Ngware, (2005) revealed that the implementation of D

by D a faced number of challenges which include reluctance or passiveness of some (MDAs) to assist LGAs for stance, there is a lack of devolving autonomy for Human Resources Management (HRM) as it has been shown in the table 13 below.

**Table 13: Challenges of D by D on PHSD by Multiple response**

<b>Types of Challenge</b>	<b>Frequency</b>	<b>Overall%</b>	<b>Individual %</b>	<b>Ranking</b>
Legal Framework	60	60%	37.0%	1
Central government	30	30%	18.5%	3
Lack of essential tools and drugs	55	55%	33.9%	2
Local government structures	17	17%	10.4%	4
<b>Total</b>	<b>162</b>	<b>162</b>	<b>100%</b>	

**Source: Fieldwork Survey, 2013**

According to the respondents the following are the leading challenge, which hinders the implementation of D by D on PHSD at Dodoma Urban District;

#### **4.4.1 Legal framework**

It is obvious that legal framework in terms of laws and by laws that existing creating a challenges within the LGAs to fail to devolve Health Services according to local need priorities. The CG imposed different directives through constitutional and bill of rights that suppress that of LGAs. According to the questionnaire distributed large number 37 (37) selected legal framework compare to other challenges in such a way it became difficult for LGAs to perform its duties effectively.

#### **4.4.2 Lack of essential drugs and reagents**

Through questionnaire distributed 33 (33%) of respondents identified lack of drugs and reagent as the challenge that face D by D in PHSD at Dodoma Urban District. They also asserted that even the MSD has no enough money to purchase drugs and reagent frequently compounded with delays, storage and transportation problems particularly accessibilities to many health centres and dispensaries. Therefore, the central government should disbursed fund to LGAs in timely manner to enable them to purchaser drugs and reagents even to private institutions.

#### **4.4.3 Central government**

Besides, through the questionnaires distributed the central government failed to devolve some of its autonomy to LGAs where by 18 (18%) of the respondents selected that the central government had its upper hand in LGAs in terms of fiscal and Human Resources. In terms of fiscal challenges included salaries to pay workers lack of funds for wars maintenance fuel and other offices expenditures hence continued paused challenges to LGAs in Dodoma Urban District.

#### **4.4.3 Local government structures**

However it is observed that local government structures is among of the challenges of D by D in PHSD at Dodoma Urban District where the study founded that 10 (10%) of the respondents mentioned Local Government Structures. For example at departmental level Hospital level and Ward level such structure are reported to undertake corruption ,nepotism and created a complex bureaucracy toward PHSD at Dodoma Urban District.

Through interview conducted to the key personnel the findings revealed that 15 (37%) of the respondents pointed out lack of essential drugs and reagent. 10 (25%) of the respondents said poor working conditions such as lack of electrification, housing and

water, 10 (25%) of the respondents revealed that there was poor health infrastructure such as wards OPDs and offices, whilst, 5 (13%) of the respondent mentioned shortage of employees as shown on Table 14: below

**Table 14: Key Personnel Interview on Challenges of D by D on PHSD**

<b>Types of Challenge</b>	<b>Frequency n = 40</b>	<b>Respondents (%)</b>
Lack of Essential Drugs and reagent	15	37
Poor Working Conditions	10	25
Poor Health Infrastructure	10	25
Shortage of Employees	5	13

**Source: Fieldwork Survey, 2013**

#### **4.4.4 Degree/Position of Central Government to assist D by D challenges on PHSD**

In this section study wanted to know the degree or position on which the CG assist LGAs to overcome challenges on PHSD at Dodoma Urban District. The respondents had the following views 70 (70) of the respondents reported the position of CG to assist D by D is low. While 15 (15%) of the respondents reported that the position of CG to assist LGAS on challenges were high, 10 (10%) of the respondents mentioned the degree of assistance from CG to LGAs was medium and 5 (5%) of respondents mentioned none as shown in Table No. 15 below

**Table 15: Degree/Position of CG to assist D by D challenges on PHSD**

<i>Degree/Opinion</i>	<i>Frequency</i> <i>n = 100</i>	<i>Respondents (%)</i>
Highly/maximum	15	15
Medium/average	10	10
Low/minimum	70	70
None	5	5

**Source: Fieldwork Survey, 2013**

#### **4.4.5 Reasons for the challenges of D by D on PHSD**

Under this section the study wanted to capture what are the reasons for the challenges faced D by D on PHSD. In responding to this question respondents came up with different views. It observed that respondents 47 (47%) mentioned poverty as being the major and serious reason for challenge, 23 (23%) mentioned burden of diseases on their areas as the area is susceptible to many epidemic and pandemic diseases, 12 (12%) respondents mentioned lack of commitment and seriousness among local government actors, 9 (9%) of respondents mentioned poor communication among policy implementors and actors, 9 (9%) respondents mentioned lack of realistic plans and community participation as shown in the table 16

**Table 16: Reasons for the Challenges by D on PHSD.**

<b>Reasons for the challenge</b>	<b>Frequency n = 100</b>	<b>Respondents (%)</b>
Poverty	47	47
Burden of Diseases	23	23
Lack of Commitment and Seriousness among Government Actors	12	12
Poor Communication between Policy Implementers and Actors	9	9
Lack of realistic Plans and Community Participation	9	9

**Source: Fieldwork Survey,2013**

Through interview made to the 40 key personell the study founded that 13 (33%) of the respondents mentioned shortage of the employees was the main reasons for challenges face D by D on PHSD, 10 (25%) Of the respondents metioned accessibility and affordability being the reasons for challenges of D by D on PHSD, while 10 (25%) of the respondents mentioned that low motivation among health sector employees also was among of the reasons for challenge of D by D on PHSD, and the rest 7 (17%) mentioned delays on the provisionsl of health busket fund as shown in the Table No: 17 below.

**Table 17: Key personell interview on reasons for challenges of D by D on PHSD**

<b>Reasons for Challenges</b>	<b>Frequency</b>	<b>Respondents</b>
	<b>n = 100</b>	<b>(%)</b>
Shortage of employees	13	33
Accessibility and Afordability of Servirce	10	25
Low motivation among Health workers	10	25
Delays on provional of health basket fund	7	17

**Source: Fieldwork Survey,2013**

#### **4.4.4 Effects of the Challenges of D by D on PHSD**

Under this section the study wanted to capture if there were the effect of these challenges of D by D on PHSD at Dodoma urban District the study revealed that 23 (23%) of the respondent pointed out that increasess of mortality amomong the Dodoma Urban District which affect life expectancy of local communities, 21 (21%) mentioned inefficiency within PHSD at Dodoma Urban District, 20 (20%) of the respondents mentioned the increasing of herbalist centres and sanitarian clinics and superstation on many places, 17 (17%) of the respondents asserted that increased of corruption within PHSD at Dodoma Urban District, 15 (15%) of the respondents mentioned that it increased the problem of brain drain where many employees shifted within PHSD to private institutions,while 4 (4%) reported that it increasess low motivation among many workers becomed stressed and failed to delivere desireable servirces , as it showed on Table18 below

**Table 18: Effects of the Challenges of D by D on PHSD**

<b>Response</b>	<b>Frequency n = 100</b>	<b>Respondents (%)</b>
Increasing of Mortality	23	23
Inefficiency within PHSD	21	21
increasment of Herbalist Centers and Sanitarian Clinics	20	20
Increasement of corruption	17	17
Increasment of Brain Drain	15	15
Low motivation within PHSD employees	4	4

**Source:Fieldwork Survey 2013**

#### **4.5.Objective Three: Measures to overcome the challege of D by D on PHSD**

##### **4.5.1 Kwoledge on the factors to improve D by D on PHSD**

The study wanted to know factors for improving D by D on PHSD at Dodoma Urban Disrict the study finding indicated that 46 (46%) of the respondent are aware on factors for improving D by D on PHSD, 54 (54%) of the respondents are unaware of the factors to improve D by D on PHSD at Dodoma Urban District.This indicated that 54 (54%) of respondents re not unaware of the factors to improve PHSD.This resulted from poor participation on seminar workshops and media that pupularize the policy for 10 years.

**Table 19: Awereness of the factors to improve D by D on PHSD**

<b>Responses</b>	<b>Frequency n = 100</b>	<b>Respondents (%)</b>
Awere	46	46
Not aware	54	54

**Source: Field work Survey, 2013**

#### **4.5.2 Factors responsible for improvement of D by D on PHSD**

From table No. 19 showed that 59 (14.8%) of the respondents suggested that LGAs autonomy as the main factor that will improve D by D on PHSD at Dodoma Urban District, 55 (13.8%) of the respondents reported that improvement of MSD distribution mechanism was the second factor for improvement of D by D PHSD, the third factor was poverty reduction with 50 (12%) to be improved in order D by D to provide reliable service to members of community, 47 (11.8%) of the respondents suggested the fourth way to improve D by D on PHSD was to formulate realistic plans that are embodied to the local needs and implementable, while 42 (10%) of all respondents suggested that changing of funding mechanism will enable to improve PHSD at Dodoma Urban District, besides 34 (8.2%) of the respondents reported that there should be a legal demarcation that define scope and function of LGAs against those of CG in order to improve PHSD, 27 (6.7%) of the respondents suggested the way to improve D by D was improvement of participation and involvement that will improve PHSD while, 24 (6.2%) of the respondents suggested the way to improve D by D as the increased provision of education and vaccination campaign in order to improve PHSD, 21 (5.2%) of the respondents suggested that the establishment of many internal pharmaceutical industries will enable to supplement the shortage and cost effectiveness for MSD, 21 (5.2%) of respondents was of the opinion that reforming legal framework as the way to improve PHSD at Dodoma Urban district, 11 (2.7%) they are of opinion that change of the funding mechanism was the way forward to improve D by D on PHSD.

**Table 20: Factors for improvement of D by D on PHSD**

<b>Factors</b>	<b>Frequencies</b>	<b>Overall %</b>	<b>Individual %</b>
Poverty reduction	50	50%	12.5%
Demarcation between CG and LGAs	34	34%	8.2%
Increases ccessibility and Afordability of PHSD	42	42%	10.5%
Increase Vaccination and Education	25	25%	6.2%
Change in Funding mechanism on PHSD	11	11%	2.7%
Increase Participation of local community	27	27%	6.7%
Formulate realistic plans	47	47%	11.8%
Improve of MSD distribution machanism	55	55%	13.8%
Establish internal Pharmaceutical industry	21	21%	5.2%
Motivating employee	10	10%	2.5%
Reforming Legal framework	17	17%	4.2%
LGAs autonomy	59	59%	14.8%
<b>Total</b>	<b>398</b>	<b>398%</b>	<b>100%</b>

**Source: Fieldwork Survey, 2013**

Through interview conducted to the key personnel respondent come up with different views 27 (67%) of respondents pointed out that the central and sector ministry should stop govern through directives. Moreover, CG stops directing LGAs to perform activities under the expenses of LGAs planning. Meanwhile 8 (20%) of the key respondents mentioned the demand for strategic leadership, while the last group of respondents 5 (2.5%) asserted that LGAs should adequate mobilized her own source of revenue like propriety rates and other which are necessary to co-finance PHSD and increases governance and accountability as showed in the Table20: below

**Table 21: Key personnell response of D by D on PHSD**

<b>Responses</b>	<b>Frequency n = 40</b>	<b>Respondents (%)</b>
CG should Stop govern by directives	27	67
Demand for strategic leadership	8	20
LGAs should adequate mobilize her own resources	5	13

**Source: Fieldwork Survey,2013**

#### **4.5.3 Applicability of Ways to improve D by D in PHSD at Dodoma Urban**

In responding to this question on applicability of ways to improve D by D in PHSD at Dodoma Urban District the study found that 68 (68%) of the respondents were of the opinion that these ways are applicable, while 32 (32%) mention are not applicable due to the fact that D by D is highy politicized rather than realistic implementation and highly dependend from donar countries for its resource mobilization as it shown in Table 20: below

**Table 22: Applicability of ways to improve D by D on PHSD**

<b>Response</b>	<b>Frequency n = 100</b>	<b>Respondents (%)</b>
Yes	68	68
No	32	32

**Source :Fieldwork Survey, 2013**

#### **4.5 Summary**

This chapter provided information on areas of the study and demographic characteristics of respondents, and presented the findings and data analysis on the roles and challenges of D by D on PHSD at Dodoma Urban District. The major findings on three objectives reflect that the revealed that 70 (70%) of the respondents at Dodoma Urban District was unaware

on the roles of D by D on PHSD because the policy is not well popularized to the grass root level. Thus become difficult to implement due technocratic and top –down policy approach in Dodoma Urban District. 60 (60%) of the respondents failed to mention roles of D by D on PHSD only 40 (40%) were able to mention correctly but mostly these include heads of sections who are the policy implementers.

On other hand the study showed that the common opinion of majority once asked on effectiveness of the D by D remained undecided because the policy is not well sensitized and popularized to them. Despite majority of respondents 55 (55%) appraised D by D roles are applicable. Meanwhile the majority of the respondents 50 (50%) appraised the extent of PHSD at Dodoma Urban District. The other 25 (25%) of the respondents appraised to 25%, 13 respondents appraised 75% and 12 respondents appraised to 100%.

However the policy of D by D is subjected to a number of challenges where by 40 (40%) of respondents mentioned Legal framework, 30 (30%) of the respondents mentioned central government. Apparently the study also find out respondents opinion on the reasons for challenges as it showed to be 47 (47) of respondents mentioned poverty, 23 (23%) mentioned poverty all these impede the robust of the policy.

Moreover the study captured responses suggestion on ways to improve D by D on PHSD where by 59 (14.8%) of the respondents suggested that increases LGAs outonomy. On other hand 55 (13.8%) of the respondents reported that mprovement of MSD distribution machanism, while 50 (12%) of the respondents suggested on poverty reduction strategies.

## CHAPTER FIVE

### CONCLUSION AND RECOMMENDATIONS

#### 5.1 Introduction

The main objective of this study was to examine roles and challenges of D by D on PHSD at Dodoma region the case of Dodoma Urban District. In addition, specific objective were to examine the role of Decentralization by Devolution in PHSD at Dodoma urban district, to examine the challenges of decentralization by devolution in health service delivery in Dodoma rural district and to suggest measures to overcome challenges. The chapter covers the conclusion, which based on major findings and suggests recommendations that are given to Dodoma urban district and to the Central government. Moreover the chapter identifies areas for further research.

#### 5.2 Summary of the findings.

I was observed that 25 (65%) of the key respondents are aware on the roles of D by D on PHSD at Dodoma Urban District, and 15 (37%) of the respondents were unaware, this might be causes by poor policy implementation approach such as top-down approach compounded with shortage of training on many LGAs employees. In terms of household members the study found that 55 (91%) of the respondents are not aware on roles of D by D on PHSD. Generally it can be concluded that from both 100 respondent about 70 (70%) were not aware on the roles of D by D on PHSD at Dodoma Urban District. However 40 (40%) of the key respondents were able to mentioned correctly the role of D by D while the rest 60 (60) failed to mention correctly roles of D by D.

It was found out that the common opinion on the effectiveness of D by D on PHSD by using Likert scale remain undecided they were unable to asserted on the effectiveness of

the policy because they were not involved ,participates and policy sensitization. Moreover the study found out that 55 (55%) of the respondent pointed out that roles of D by D are not applicable

It observed that the extent of D by D on PHSD was 50% where 50 respondents appraised by (50%) 25 respondents appraised to 25%, 13 respondents appraised to 75% and 12 respondents appraised to 100%.

It was observed that the policy of D by D on PHSD found enormous waves of challenges where by 40 (40%) of the respondents rated legal framework being the major factor followed by 30 (30%) of respondent who pointed out local government structures, 25 (25%) mentioned lack of essential drugs and reagent.

In addition the study found out reasons for challenges 47 (47%) of the respondents mentioned poverty as a major reasons challenging PHSD.Appart from that 23 (23%) of the respondents mentioned burden of diseases.While 12 (12%) respondents mentioned lack of commitment and seriousness among local government actors,9 (9%) of respondents mentioned poor communication among policy implementors and actors,9 (9%) respondents mentioned lack of realistic plans and community participation.These challenges also causes threats to the livelihood of communtiy.

It was observed that, there are ways forward to overcome challengies where 59 (14.8%) of the respondents suggested that LGAs outonomy, 55 (13.8%) of the respondents reported that mprovement of MSD distribution machanism, 50 (12%) to be improved inorder D by D to provide reliable servirve to members of community, 47 (11.8%) of the respondents suggested the formulation realistic plans that are embodied to the local needs and emplemtable,while 42 (10%) of all respondents suggested that changing of funding mechanism will enable to improve PHSD at Dodoma Urban District.

## **Conclusion**

Basing on the information gathered through questionnaires, interview, and participatory observation one may conclude by saying that

The implementation of D by D on PHSD at Dodoma urban district is not fully popularized to local community as larger number of respondents 70 (70%) were not were not aware on roles of D by D on PHSD. The extent of D by D on PHSD at Dodoma Urban district not fully achieves. The policy of D by D on PHSD faced challenges the biggest one being legal framework and, Human resources management not devolved within LGAs. The reasons for challenges of decentralization by devolution on health service delivery at Dodoma urban District includes, poverty, burden of diseases, lack of commitment and seriousness among government actors, poor Communication between policy implementers and actors and lack of realistic plans and community participation

Finally some ways proposed by respondents in order to improve decentralization by devolution on public health services delivery at Dodoma Urban district. These includes, poverty eradication strategies, vaccination campaign, education on various diseases such as degenerative diseases, and funding of Health system regularly by providing basket fund timely, while increases of participation and communication among all policy stakeholders to enable both vertical and horizontal accountability within health system.

## **5.3 Recommendations**

Basing on the research findings emerged from the study the following recommendations and the way forward made.

Firstly and foremost education, sensitization campaigns should be increases to enable D by D popularization, this should be done by using mass media on job training seminars

workshops and village meetings. The central government should shift its paradigm on policy formulation from top-down approach to bottom up approach.

There is a need to give more autonomy to LGAs to perform its duties without interference of the central government particularly on fiscal and human resources management to enable LGAs to employ and fire its employees than current situation where the employment vest under the Presidential Office. Reshuffled of LGAs structures that interfere with D by D policy on PHSD at Dodoma Urban District to enable effective implantation of the policy.

Moreover it recommended that community participation is very important ingredient towards rapid development as from study finding there is a need to increases community participation and awareness on decentralization by devolution. Through bottom –up approach it enable the larger extent of community involvement and hence improving the welfare of the people through decentralization by devolution within the health sector.

Moreover it recommended that the lower cadres' employees and grassroots leaders should be sensitized and given training on decentralization by devolution due to the fact that they are more responsible person to supervise policy at their areas.

Lastly, the study recommended on the modalities for enhancing availability accesses and affordability to drugs and medical supply and equipment need to be distributed timely to enable it availability to health centres. This reduced frequently complain to clientele at Dodoma urban district.

#### **5.4 Areas for further Research**

The aim of the study is to analyze the roles and challenges of decentralization by devolution on public health service delivery. The study could not cover all the aspects of decentralization by devolution .Further research should be on the following topics

- i. The impact of decentralization by devolution on provision of secondary education in Tanzania.
- ii. The influence of legal framework on decentralization by devolution on public health service delivery
- iii. A comparative analysis of Delegation and Devolution on PHSD at the District Level.
- iv. The effects of opportunity and obstacle approach towards health service delivery in LGAs in Tanzania.
- v. The impact of poverty on health service delivery at Dodoma municipality.

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## APPENDICES

### Appendix1. Questionnaire for all respondents

Dear respondents,

I am James Raymond a graduate of University of Dodoma undertaking Masters Degree of Arts in Development studies. In order to support to undertake my dissertation, I will be very grateful if you will respond to my questionnaires .The study topic is “Roles and Challenges of Decentralization by devolution on Public health services delivery”: *A case of Dodoma Urban District*. Am insuring you that all information will be treated discretion and confidential for the purposes of research only.

Instructions:

Please tick the appropriate box corresponded to the correct response

#### A. Personal information (Profile of Respondent)

1. Gender (a) Female  (b) Male

2. Age group

- (a)  18-30 years  
(b)  31-40 years  
(c)  41-50 years  
(d)  51-60 years

3. What is your marital status?

- (a) Single   
(b) Married   
(c) Widow   
(d) Divorced

4. What is your Education level?

- (a) Masters degree

- (b) Degree Level
- (c) Diploma Level
- (d) Advanced Level
- (e) Ordinary Level
- (f) Primary Level
- (g) None of the above

**B. Knowledge on the roles and challenges of decentralization by devolution**

1. Are you aware of the Policy of D by D on Public Health service Delivery?

- (a)  Yes
- (b)  No

2. Mention the roles of decentralization by devolution on Public health service delivery at your area?

- (a) .....
- (b) .....
- (c) .....
- (d) .....
- (e) .....

3. To what extent does D by D roles are effective in Public Health Service Delivery

(Please write the weight number in the box provided)

- (a) Very effective      5
- (a) Effective            4



- (b) .....
- (c) .....
- (d) .....

9. What is the Degree/Position of Central Government to assist D by D challenges on Public Health Service Delivery?

- (a) Highly/maximum
- (b) Medium/average
- (c) Low/minimum
- (d) None

10. What are the effects of challenges of D by D on Public Health Service Delivery

- (a) Increasing of Mortality
- (b) Inefficiency within PHSD
- (c) increasment of Herbalist Centers and Sanitarian Clinics
- (d) Increasement of corruption
- (e) Increasment of Brain Drain
- (f) Low motivation within PHSD employees

11. Are you awereness of the factors to improve D by D on PHSD

- (a) Awerere
- (b) Not awere

12. What are the ways to overcome challenges of D by D on Public Health service delivery (Please choose all factors you know)

- (a) Poverty reduction

- (b) Demarcation between CG and LGAs
- (c) Increases ccessibility and Afordability of PHSD
- (d) Increase Vaccination and Education
- (e) Change in Funding mechanism on PHSD
- (f) Increase Participation of local community
- (g) Formulate realistic plans
- (h) Improve of MSD distribution machanism
- (i) Establish internal Pharmaceutical industry
- (j) Motivating imployee
- (k) Reforming Legal framework

13. Are these ways applicable to overcome challenges of D by D on Public Health Service Delivery?

- Yes
- No

14. From your own opinion what are the reasons for challenges of D by D on Public Health Service Delivery at Dodoma Rural District.?

- (a) .....
- (b) .....
- (c) .....
- (d) .....

15. What should be done to improve decentralization by devolution on Public health service delivery?

- (i) .....

- (ii) .....
- (iii) .....
- (iv) .....
- (v) .....

**Thank you for your response**

## **Appendix II: Interview guide for key informants**

1. What are the roles of Decentralization by Devolution in health service delivery Dodoma urban district?
2. What are the challenges of decentralization by devolution in health service delivery in Dodoma rural district?
3. What are the reasons for these challenges?
4. What are the way forwards to improve decentralization by devolution on public health service delivery at your district?