THE ASSESSMENT OF PROVISION OF HEALTH SERVICES IN GOVERNMENT HOSPITALS: A CASE OF DODOMA REGIONAL REFERRAL HOSPITAL

By

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CERTIFICATION

The undersigned certifies that has read and hereby recommends for acceptance by the University of Dodoma a dissertation entitled: ***"The Assessment of Provision of Health Services in Government Hospitals: A Case of Dodoma Regional Referral Hospital"*** in partial fulfillment of the requirements for the Degree of Master of Public Administration of University of Dodoma.

Signature……

Dr Mark Paul Diyammi

(SUPERVISOR)

Date……

DECLARATION AND COPYRIGHT

I, **Paul Masanja,** hereby declare that this thesis is my own original work and that it has not been presented and will not be submitted to any other University for a similar or any other degree award.

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DEDICATION

First and before all, dedicated of this work be to the Almighty God, the very source of my life and academic excellence.

To my beloved wife (Violet) and lovely children (Innocent, Kate and Adriely) be also dedicated. You have always been praying for me and endured loneliness when I was away for studies. God bless you all.

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ABSTRACT

Assessment of provision of health services in government hospitals is a study that was conducted at Dodoma Regional Referral Hospital as a study case, and it was mainly focused on assessing various aspects associated with the general provision of health services and the way clients of such services perceived. Perceptions of health service providers about non-salary incentives they receive from the government and managerial capacity in ensuring the provision of reliable health service.

A sample of 90 (ninety) respondents was used and these were randomly obtained from Dodoma Regional Referral Hospital. The methods used in data collection were interviews, questionnaire, documentary review and focus group discussion. The statistical package for social science (SPSS Version 21) was used for management of data and analysis.

The study reveals that health provision practices are done through two service provision options namely fast track and non fast track. The study also unveils that the former option is delivered in relatively high quality than the latter. Besides, this analysis further divulges that some service providers prefer fast track more than non fast track service because it has been found that service providers are given some incentives from the money that patients pay for the fast track service. The perceptions of service providers on non salary incentives showed that all workers are not satisfied with the currently provided incentives. In addition the study revealed that managerial capacity for the administrative organ for Dodoma Regional Referral Hospital has not been able to discover and hence execute disciplinary measures to any worker for a long period of time which indicates low managerial capacity in handling service provision malpractices.

Given these findings, the study recommends that the government increases subsidies to hospitals which provide fast track service so that the costs associated with providing such service be reduced and increase an opportunity for more people to receive fast track service.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
EU	European Union
GDP	Growth Domestic Product
HIV	Human Immunodeficiency Virus
LGRP	Local Government Reform Programme
LSRP	Legal Sector Reform Programme
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
NACSAP	National Anti-Corruption Strategy and Action Plan
PCA	Punishment Corruption Act
PCCB	Prevention and Combat of Corruption Bureau
PFMRP	Public Financial Management Reform Programme
PSRP	Public Sector Reform Programme
RoK	Republic of Kenya
SPSS	Statistics Package for Social Science
TI	Transparency International
UDOM	University of Dodoma
UN	United Nations
UNDP	United Nations Development Programme
URT	United Republic of Tanzania
US	United States
WB	World Bank
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.0 Introduction

Strengthening service delivery is crucial to the achievement of the health-related Millennium Development Goals (MDGs), which include the delivery of interventions to reduce child mortality, maternal mortality and the burden of HIV/AIDS, tuberculosis and malaria(WHO, 2010). Service provision or delivery is an immediate output of the inputs into the health system, such as the health workforce, procurement and supplies, and financing. Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system (WHO, op.cit.).

1.1 Background Information to the Study

Health services provision varies around the world. Almost all wealthy nations provide universal health care (the US is an exception). Health provision is challenging due to the costs required as well as various social, cultural, political and economic conditions (Anap, 2011). This chapter focuses on; background to the study, statement of the problem, intention of the study, objectives of the study, research questions, and significance of the study, Limitation of the study and winds up with the general conclusion of the chapter.

The citizens of the European Union spend more than 1 trillion euro a year on healthcare. However, the healthcare sector is one of the areas that are particularly vulnerable to corruption (EU, 2013). Bribes, corrupt officials and mis-procurement

undermine health care delivery in much the same way they do for police services, law courts and customs whose functions become compromised by the culture of poor governance and corruption (Lewis, 2006).

In Africa, a few examples can be cited to show prevalence of corruption cases in health provision services; in its 2006 Global Corruption report, Transparency International (TI) "has identified the health sector of Ghana as a corruption prone area with evidence of bribery and fraud across the breadth of medical services. This is said to have emanated from petty thievery and extortion, to massive distortions of health policy and funding, fed by payoffs to officials in the sector" (Ghanaian Chronicle, 2 February, 2006).

The provision of health services in Tanzania is mostly provided by the public sector while private sector plays a complementing role, Private service providers cover only one-third of all health care services in Tanzania (White. 2013). The provision of health services is currently facing a number of challenges ranging from financial based to non-financial based factors. Generally the public sector has been convicted by many citizens, that it delivers relatively low quality health service when compared with the private sector. There are many factors contributing to this situation, which include financial constraints and questionable integrity of service providers, which is manifested through corruption tendencies.

Hence it has generally been known as the use of public office/authority and other associated privileges for private gain. Corruption has become an epidemic problem in recent development ventures of many countries in the world, especially the third world countries (Shyamal, 2010). World Bank has estimated that 1 trillion dollars from these ventures have been used as bribe-money, accounting for 3% of the global GDP (Rose-

Ackerman, 2004). This massive loss of public money suggests that corruption is a major obstacle to economic development, which can, in-turn be translated into poor delivery of social services such as health, education, infrastructure, water and sanitation just to mention but few. Although statistics shows worse situation in most of the developing countries as far as corruption is concerned, but the problem is experienced in almost every country in the world, although with varying degrees of intensity.

In Tanzania, corruption has also been experienced since independence in almost every sector especially those involved with public service delivery (World Bank, 2000). The Government has been battling against corruption since the early days of independence, and efforts have been re-doubled with the adoption of a new and comprehensive anti-corruption strategy, which came with an introduction of Prevention and Combating Corruption Bureau (PCCB), whose major role is dealing with corruption in Tanzania (Afro-barometer, 2006). According to PCCB reports, health service delivery is one among the sectors that has adversely been affected by corruption (Anti-corruption network, 2008). It has been reported from health sector that, both health workers and the general public recognize the negative impacts of corruption but feel trapped in a system from which they cannot escape (Muhondwa, 2010). The system in which corruption works makes health workers who are not inclined in corruption to find them unable to take action against their colleagues who are involved. In addition, the relatives of patients who fail to pay bribe have found themselves in the consequences, which include death of their loved ones due to lack of timely medication or timely nursing interventions (Muhondwa, op.cit). In Dodoma, especially the Dodoma Regional referral hospital has been accused by many people of being biased in service delivery by pointing out that, it is only the rich and those people with friendly or bloodily relationships with the hospital workers who enjoys the services.

1.2 Statement of the Problem

The challenge of provision of unreliable health services in Tanzania has been associated with corruption tendencies. Corruption has been in existence for a long time in Tanzania, and the government has tried to address it using different approaches. During the colonial period, British Colonial rule established Punishment Corruption Act (PCA), which among other things; it dealt with passing judgement for the offenders who were caught committing corruption offence. Other strategies include issuing and amending code of ethics and conduct for public services, Public Leadership Code of Ethics Number 13 of 1995 and Establishment of Prevention and Combat of Corruption Act No.11 of 2007 with the major objective of promotion and enhancement of good governance and eradication of corruption (PCCB, 2013). In addition, the government established the National Anti-Corruption Strategy and Action Plan (NACSAP) phase I&II had the same goal of preventing and combating corruption. The deployment of all these strategies implies theoretically that; corruption could have gone away a long time ago, and community members could enjoy quality and reliable healthy services from service providers. Contrary to this expectation however, the provision of unreliable health service continue prevailing in our country. In addition, Dodoma being the capital city of Tanzania, one could think of it playing a role model to the rest of cities in Tanzania especially on service provision, but contrary, worse situations have been reported by the recipients of health service from Dodoma regional hospital. These claims from health service recipients suggests that, a study must be done to investigate the factors which influence the persistence of provision of unreliable health services in Dodoma Regional Referral Hospital.

1.3 Objectives of the Study

Research objectives categorized into two categories namely general objective and specific objectives.

1.3.1 General Objective

The general objective of this study was to assess the health provision services in Dodoma Regional Referral Hospital.

1.3.2 Specific Objectives

i. To assess health service provision practices in Dodoma Regional Referral Hospital.
ii. To explore the perceptions of health service providers about non-salary incentives they receive from the government.
iii. To evaluate managerial capacity in ensuring the provision of reliable health service.

1.4 Research Questions

i. What are the general practices of health service provision in the study area?
ii. What are the perceptions of health service providers about non-salary incentives they receive from the government?
iii. What is the managerial capacity in ensuring the provision of reliable health service?

1.5 Significance of the Study

Provision of reliable health services is very important to insure development in social, political and economic activities of any nation.

The information generated from this study will be helpful to all stakeholders of health service, which includes; policy makers, planners, health service providers, and the general community at large who are beneficiaries of the health service.

The information from this study will inform planners and decision makers on the factors that contribute to unreliable health service provision in Dodoma Regional Referral Hospital, and the information will be used as inputs in preparing implantable plans and make informed decision as they endeavour to prevent and combat those problems in health sector in Tanzania.

Recipients of health service will benefit from the results of this study because they will understand their responsibility to improve health service provision.

Since it is claimed that corruption is among leading factors that led to unreliable health services provision; PCCB on the other hand will benefit from the results of this study, because it will provide them with insights on the drivers of corruption in places where health service is provided and hence develop appropriate intervention strategies against corruption.

1.6 Limitations of the Study

i. The study was conducted without fund, hence financial limitation during the collection of data like payment of transport and internet services.
ii. Data collection tools were designed in English then translated in Swahili, and analysis done in English.
iii. Hiding of the information concerning to factors affecting health provision services from some Respondents.

1.7 Scope and Organization of the Study

The study is planned into five chapter manner. In each chapter in depth information concerning the subject matters of the study was described. The research study included the following chapter manners:-

Chapter one presented the background, the statement of the problem, research objectives, and the appropriate research questions. The significance of the study also was presented in this chapter, scope and organization of the study as well as the conclusion of the chapter. Chapter two critically analyzed the comprehensive literature review which relates to health service provision in Tanzania. Theoretical literature review, conceptual framework, analytical review and empirical review which concerning health services provision in Africa and Tanzanian specifically Dodoma Regional Referral Hospital were discussed. Chapter three is about the research methodology by presenting the research design, description of the study area, population of the study, sample size and sampling design. Also, this chapter showed clear description of how data were processed, analyzed and presented. Finally, reliability and validity of data was also considered. Chapter four provided the analysis of research results. This was organized through presenting and discussion and finally interpretation of data. Chapter five dealt with presenting the summary of the study, conclusion and recommendations. Further, it was also indicated areas for further study.

1.8 Summary

The study concerned with the Assessment of health provision services in Government Hospitals especially in Dodoma Regional Referral Hospital". This chapter concerned with the discussion of the background to the problem, statement of the research problem, research objectives, research questions, and significance of the study.

It was ended up with the scope of the study and conclusion of the chapter. The next chapter, concentrates on the Literature Reviews on this topic of health provision in government hospitals.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

According to Barley (1999) review of literature refers to the process of discovering, reading, weighing up, shortening and incorporating in your study documents having materials which are related to the problem under investigation. The purpose of literature review is to familiarize the reader with the practical or theoretical issues relating to the problem and helps the researcher to lay a foundation for the study. A literature review indicates what is known about the area of inquiry and suggests ways of conducting the study on the topic of interest. This chapter focuses on introduction, theoretical literatures review that includes description of concepts and theories, empirical analysis, conceptual framework, Research gap and its conclusion or summary.

2.1 Definitions of Key Concepts

2.1.1 Concept of Health

The term refers to a state of complete physical, mental and social well-being. Health is as much a social as it is a biological issue, because well-being and illness have their root in the organization of society (Maccions, 2005). Also health refers to the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental) and is largely culturally defined (WHO, 2004).

2.1.2 The Term Health Services

This concept includes all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services. Health services are the most visible functions of any health system, both to users and the general public. Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions. Improving access, coverage and quality of services depends on these key resources being available; on the ways services are organized and managed, and on incentives influencing providers and users (WHO, 2011).

2.1.3 Basic Health Service

This conception means a network of health units providing essential health care to a population. Basic health services include communicable disease control, environmental sanitation, maintenance of records for statistical purposes, health education of the public, public health nursing and medical care (WHO, 2004).

2.1.4 Referral

The word referral can be defined as any process in which health care providers at lower levels of the health system, who lack the skills, the facilities, or both to manage a given clinical condition, seek the assistance of providers who are better equipped or specially trained to guide them in managing or to take over responsibility for a particular episode of a clinical condition in a patient (Al-Mazrou, 1990).

Also referral is defined as the direction of people to an appropriate facility, institution or specialist in a health system, such as a health centre or a hospital, when health

workers at a given level cannot diagnose or treat certain individuals by themselves, or face health or social problems they cannot solve by themselves (WHO, 2004).

2.1.5 Referral Hospitals

When it concerns referral hospitals, these have a broader effect on overall societal welfare than can be captured by measures of health outcomes. Utility, or welfare, includes health as one of many important outcomes, such as financial security, risk alleviation, and psychological reassurance ((Al-Mazrou, op.cit.).

2.1.6 Regional Referral Hospital

Regional referral hospital is a regional health care market for specialized consultative care, where caring for the patient requires the services of a major referral center. Therefore one can define regional referral hospitals as hospitals that provide more specialized care and the next level of referral for more complicated cases, in addition to general inpatient care, outpatient services, laboratory care, and surgeries (Al-Mazrou, op.cit.).

2.1.7 Community

This can be defined as a group of people, often living in a defined geographical area, who share a common culture, values and norms, and are arranged in a social structure according to relationships which the community has developed over a period of time.

Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them (WHO, 2004).

2.1.8 Disease

The concept means a failure of the adaptive mechanisms of an organism to counteract adequately, normally or appropriately to stimuli and stresses to which the organism is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multifactorial and may be prevented or treated by changing any or a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined. Thus, criminality and drug dependence are presently seen by some as diseases, when they were previously considered to be moral or legal problems (WHO, 2004).

2.1.9 Health System

This embraces the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities, the primary intent of which is to improve health. Health systems fulfill three main functions: health care delivery, fair treatment of all, and meeting non-health expectations of the population. These functions are performed in the pursuit of three goals: health, responsiveness and fair financing.

A health system is usually organized at various levels, starting at the community level or the primary level of health care and proceeding through the intermediate (district, regional or provincial) to the central level (WHO, 2004).

2.1.10 National Health Policy

A formal statement or procedure within an institution (notably government) which defines goals, priorities and the parameters for action in response to health needs, within the context of available resources (WHO, 2004).

2.1.11 Government Hospital

A government hospital is a place for intensive care and short or long-term medical treatment open to all sorts of patients, which is operated by a governmental body or by an organization belonging to a government. This does not include military or veterans' hospitals (Williams, 2006).

2.1.12 Management

The sums of the measures taken to plan, organize, operate and evaluate all the many interrelated elements of a system is known as management. Such measures are required to translate policies into strategies and strategies into plans of action for determining the action required to define and operate health programmes and ensure that the health system infrastructure is built up to deliver them efficiently and effectively (WHO, 2004).

2.1.13 Corruption

The term corruption has variably been defined by many scholars/researchers. Mulgan (2012) for example, argues that, corruption differs depending on whether they focus on the responsibilities and duties of public office and office holder, on compliances of law and legally defined standards or more broadly on the clash between illegitimate personal interest and the public interest. According to Ahmed, (2004) corruption is an act where power and/or position are misused, to create opportunities for exploiting or expropriating resources. Lipset and Lenz, (2000) describe corruption as obtaining wealth or power through illegal practices, providing someone with personal gain at the public's expense. Hence, these actions violate societal standards and norms, and they are likely to occur when there is an absence of accountability in society (Ahmed, 2004). According to Alemann, (2004), corruption is a multi-faceted phenomenon, consisting

of social decline, deviant behaviour, logical exchange, perceptions, and shadow politics. Any action containing all five of these features can be considered as corruption. For the purpose of this study the concept of corruption by Ahmed (2004) will be used that corruption is an act where power and/or position are misused, to create opportunities for exploiting or expropriating resources.

2.2 Theoretical Literature Review

A theoretical framework is a skeletal structure of justification rather than a skeletal structure of explanation based on accumulated experiences (Eisenhart, 1991). The framework had to guide research process through showing the relation of variables which explain cause and effect. The researcher acknowledges the fact that there are different theories based on Health Service Provision but only a few will be explored here, namely, Scientific Accountability and Citizen Voice theories.

This study is guided by two theories, which informs the researcher on how to approach the study. The theories which inform this study include the accountability theory and the citizens' theory.

2.2.1 Accountability Theory

Segal (2002) who is the proponents of accountability theory argued that; accountability is government's obligation to demonstrate effectiveness in carrying out goals and producing the types of services that are wanted or needed by the public. Therefore, lack or absence of accountability in public offices may create loophole to corruption practice. Brinkerhoff (2004) identifies three key components of accountability, these are; measurements of goals and results, the justification and explanation of that results to internal and external monitors and punishment and sanctions for non-performance or corrupt behaviour.

Brinkerhoff also come up with strategies to increase accountability which include; Information systems, watchdog's of organizations, health boards and other civic organizations. All these could measure how input is used to produce output and demand explanation in particular results also may demand performance incentives to best performer and sanctions to poor performer.

The relevance of this theory in the corruption studies is that, it helps the research understand that one among the factors that may influence corruption is accountability. The theory further asserts that, if the administrative body is to be effective in preventing and combating corruption, it has to apply some preventive strategies as they have been explained above. In this study therefore; the research will use the suggested strategies as variables to measure how capable and willing, is the administration of Dodoma general hospital in preventing and combating corruption.

2.2.2 Citizen Voice Theory

Citizen voice refers to the channels and means for active participation by stakeholders in planning and provision of services (Thomson, 2005). It is argued that one purpose of citizen voice is to increase external accountability of the government. The theory further argues that; strategies to promote citizen voice include local health boards where citizens can have input in to the budgeting and planning process; patients survey to provide feedback on satisfaction; and complaint offices to record and mediate reports of unethical or corrupt conduct.

The relevance of citizen voice theory in this study lies on the fact that, it realize that, the citizens (who in this context may be referred as health service recipients) are important part in prevention and combating corruption, because they have a vital role to play in either stopping it or accelerating.

The researcher will use the insights suggested by this theory in approaching service beneficiaries and assess them how far do they contribute in the existence of corruption problem so that appropriate measures can be taken to halt the situation (Mendelberg, 2002).

2.3 Empirical Review

This part looks at the context of health services provision and National Health Policy, also analyses various researches that have been taking place in relation to corruption particularly in health service provision and the perception of the society on government efforts to in combating corruption. The performance of a country's health system ultimately shapes its population's health outcomes experienced, influencing the ease or difficulty with which individuals can seek care and facilities can address their needs.

Assessing health system performance is crucial to optimal policymaking and resource allocation; however, due to the multidimensionality of health system functions (Murray, 2000). Rigorously measuring what factors are contributing to or hindering health system performance access to services, bottlenecks in service delivery, costs of care, and equity in service provision throughout a country, provides crucial information for improving service delivery and population health outcomes (IHME, 2015). The next part is going to look an overview of health systems of different nations particularly on health service provision.

2.3.1 Health Service Provision in Europe

Taking an example of Poland as the largest country in central and eastern Europe in both population (38.1 million) and area (312 685 km2). Since the successful transition to a freely elected parliament and a market economy after 1989, Poland is now a stable democracy with constant economic growth and is well represented within political and

economic organizations in Europe and worldwide. The health status of the Polish population has improved substantially, with average life expectancy at birth reaching 80.2 years for women and 71.6 years for men in 2009 (Mossialos, 2011).

The beginnings of the Polish health sector and its public activities can be traced back to the period of Polish independence between 1918 and 1939. The Law on Health Insurance, which came into force in 1920, covered only wage-earning employees: about 7% of the population. It was based on the German system of sickness funds (the so-called Bismarckian model) but it put more emphasis on the territorial structure of the sickness funds and their self-governance (Sadowska, 1993).

Prior to 1989, health care in Poland was organized according to the Soviet Semashko model, in which the state was responsible for the financing, regulation and provision of health care. The post-communist health care system that has gradually evolved since the political transition is based on three principles: the redefinition of responsibilities for health care, the creation of a health insurance system, and the separation between payers and providers of health services. This has led to the emergence of new stakeholders in the health sector; local governments, for example, have assumed responsibility for aspects of health care, such as health promotion services, and have assumed ownership of almost all health facilities (Rechel, 2006).

The introduction of health insurance has changed the organization of health service provision in Poland. Sickness funds enter into contracts with health care providers who provide a defined package of services for the insured. The notion of choice plays a significant role. Patients can choose the health care provider, introducing an element of competition, with the financial resources of public and private health care providers coming from contractual agreements with health insurance funds.

Also introduction of the health insurance system, competition between service providers has been encouraged. In 1990, physicians, dentists, psychologists, nurses and midwives were allowed to operate private practices. Privatization sought to improve the quality of health services, and to provide patients with easier access to physicians. One change in this direction has been the introduction of private practices of family doctors or dentists. When private providers sign contracts with health insurance funds, they are granted certain privileges associated with public providers, such as the license to prescribe pharmaceuticals at reduced costs and free referral to hospitals (Rechel, op.cit.).

In spite of all these achievements of improving health service provision in Poland, health service provision in Poland still face challenges in provision quality healthcare to their people these challenges are as follows; Low salaries result in poor motivation and staff morale. As already mentioned, there is no incentive to work more than is absolutely necessary. Many physicians of Poland and dentists supplement their salaries in the public sector with private sector employment. In addition, as in the rest of central and Eastern Europe low salaries are complemented by informal payments (Lewis, 2000).

Another challenge facing health service provision in Poland is corruption; as it is concluded that In Poland, informal payments range from small voluntary gifts to the extortion of large bribes, although patients and doctors perceive informal payments rather as an expression of gratitude for the treatment provided, they may be considered a form of systemic corruption (Kubiak, 2001).

2.3.2 Service Provision in Latin America

Colombia is one of countries forming Latin America; it lies in the northwestern part of South America, bordered by the Caribbean Sea to the north and the North Pacific Ocean to the west. Colombia's continental neighbors are Ecuador and Peru to the south, Brazil and Venezuela to the east, and the Isthmus of Panama to the west. Borders with neighboring countries total 6,004 kilometers, as follows: Ecuador, 590 kilometers; Peru, 1,496 kilometers (estimated); Brazil, 1,643 kilometers; Venezuela, 2,050 kilometers; and Panama, 225 kilometers (RoC, 2007).

Colombia is well endowed with agricultural export products, energy resources, and minerals. These resources include coal, coffee, copper, emeralds, flowers, fruits, gas, gold, hydropower, iron ore, natural nickel (also known as Millerite, a compound that is a natural nickel sulphide), petroleum, platinum, and silver. Colombia ranks first in Latin America for its coal reserves (with 7.4 billion metric tons of proven and recoverable reserves), fourth for natural gas (proven commercial reserves of around 114.4 billion cubic meters as of 2005, or enough to last until about 2022); and sixth for oil (1.4 billion proven barrels at the end of 2005, or enough to prevent Colombia from becoming a net oil importer until 2010–11). In addition, the country is second only to Brazil in hydroelectric potential. Potential natural gas reserves in offshore basins along the Caribbean Coast are estimated to cover 150 to 200 years of consumption. Most of the natural gas reserves are located in the Llanos Basin in the foothills of the Eastern Cordillera (RoC, op.cit.).

From 2002 to 2007, Colombia experienced an average annual growth rate of 5 percent, largely driven by an improved security situation and a favorable external environment. While economic growth slowed in 2008 and 2009, real GDP growth in 2010 began to

accelerate again with a growth rate of 4.3 percent. Economic growth over the last decade has been accompanied by poverty reduction. Between 2002 and 2009, poverty fell from 53.7 to 45.5 percent, while the proportion of the population that could not satisfy basic nutritional needs (the extreme poor) declined from 19.7 to 16.4 percent.(Torres, 2013). Like other countries in the region, Colombia is also facing the challenges of a rapidly aging population. In 2011, 9.2 percent of Colombia's population was over 60 years old, while only 1 percent was over 80 (United Nations, 2011). This demographic transition is likely to create a significant financial burden on the health system.

The treatment of these conditions increases the cost of ambulatory and inpatient care (that is, the demand for long-term use of medicines, more complex diagnostic and monitoring procedures, physical therapy, and so forth). Research has shown that, for example, management of hypertension and pre-hypertensive conditions is much more expensive among the elderly (Roberts, 2002).

Before the Health Sector Reform only a third of the population was covered by social insurance, and more than half of the total expenditure for health was attributable to out-of-pocket spending. In 1993, Colombia launched the Health Sector Reform that replaced the previously segmented and low-coverage model. These changes prompted a competitive market that included insurers and health care providers (Vargaz-Zea, 2012).

In the Republic of Columbia health service providers are both public and private in this system, and all affiliates have access to a benefits plan defined by the government periodically. Alongside the official list of benefits, the system also reimburses more than 700 non included drugs and technologies that are claimed by patients through

exceptional mechanisms (judicial actions). Insurers play a very important role by administering these benefits plan to patients. At this moment, concentration is taking place in the health sector and the smaller and less efficient insurers are being absorbed by stronger competitors. Insurers operate with an insurance premium known as the Capitation Payment Unit, an amount of money transferred by the government for each individual enrolled in each company (Vargaz-Zea, op.cit.).

There are also supplementary (voluntary) health insurances known as prepaid medicine, all of which offer additional coverage to the basic benefits plan. These plans are completely funded from private spending. The system also comprises coverage for special populations such as military forces, public education workers, and the national oil company employees, all of whom have different benefits plans and do not pool their resources within the system. Finally, there is a Basic Health Plan that addresses public health issues and covers all citizens regardless of their insurance status. Municipalities and local health authorities provide health promotion and disease prevention programs through the BPH. BPH is funded from alternative sources than those of the general system. There are two complementary plans that cover health care services derived from road accidents and natural disasters (*ibid*.).

The aim of all these efforts of the Government of Columbia is to manage the benefits package, to manage processes to include the poor and vulnerable in health service provision also to push efficiency reforms toward health service provision likewise to address new challenges in health service provision and tweak financing mechanisms to align the incentives of different stakeholders in the health sector. All these will result to access of quality health services to all Columbians, however this goal not achieved due to different bottlenecks encountered during implementation which include the following, as it claimed that “The central problems facing health care system in

Colombia are corruption, the failure of the government to adequately fulfill its regulatory function, and the inherent ideological conflicts" (Francisco, 2012). All these hindered quality health service provision to their people despite all reforms made to improve health service provision to its people.

2.3.3 Health Service Provision in Asia

India has made a considerable progress in reducing fertility and mortality (WB). Indian efforts to generate growth and reduce poverty have rewarded with trendous improvements in health service provision. Health services provision in India is largely the responsibility 0f the provincial States. The central government is in charge of defining policies and providing national strategic framework, financial resources and medical education (Qadeer, 2000). The quality of service provision in public institutions varies significantly across states and between rural and urban areas (MC Donald, 2013).

The National Health Policy (NHP) in light of the Directive Principles of the constitution of India recommends "universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford"(MoHFW, 1983, 3-4).

Health Policy and Plans It was not until 1983 that India adopted a formal or official National Health Policy. Prior to that health activities of the state were formulated through the Five year Plans and recommendations of various Committees. For the Five Year Plans the health sector constituted schemes that had targets to be fulfilled. Each plan period had a number of schemes and every subsequent plan added more and dropped a few (Duggal, 2006).

The salient features of the 1983 health policy were: It was critical of the curative-oriented western model of health care, also it emphasized a preventive, promotive and rehabilitative primary health care approach, likewise it recommended a decentralized system of health care, the key features of which were low cost, deprofessionalisation (use of volunteers and paramedics), and community participation, also it called for an expansion of the private curative sector which would help reduce the government's burden and recommended the establishment of a nationwide network of epidemiological stations that would facilitate the integration of various health interventions, and lastly it set up targets for achievement that were primarily demographic in nature. Generally this policy aimed at achieving universal, comprehensive primary health care services, relevant to actual needs and priorities of the community.

Despite the implementation of this policy through various plans and schemes, Public health service provision in India is marked by poor access to services, which are often low quality and limited in range. Management of the services is influenced by powerful corporate interests (international and national) and bureaucracy-driven policy reforms that deny any meaningful popular participation in the planning, implementation and monitoring of healthcare services (MC Donald, 2013). An estimated 40% of Indians still rely on the public sector for in-patient care, but many communities either lack facilities altogether or have dysfunctional ones due to shortages of doctors and health workers, and they are left with insufficient supplies of medicines and other consumables. The introduction of user fees and major cuts in public health expenditure forced public hospitals to recover the costs of services. As a consequence, public facilities stopped supplying free medicines and diagnostics.

Today, drug supplies in public facilities do not cover all requirements and are often interrupted, making outside drug prescriptions with out-of-pocket expenditures common. Diagnostics is the main source of user fee collection across the nation, and hospitals are loathed to let this avenue go (MC Donald, op.cit.).

On the other hand it is also claimed that; Corruption is not an aberration in the public health system; it is a key dimension of power relationships that promotes rent-seeking at all levels. In many states, the single biggest source of corruption is the appointment of the chief medical officers, district medical officers and directors of health services. In states most notorious for corruption, almost all chief medical and health officers get and keep their posts by paying 'rent', which they can finance by demanding the same from junior officers and vendors. Other major sources of corruption are in procurement of consumables and equipment, as well as infrastructure creation, leading to poor performance, slow utilization of resources and a failure to meet targets. Transfers and postings are another problem. In many states once transfer season comes, a large number of providers have to pay to keep their positions. An emerging avenue of corruption is kickbacks in public-private partnerships and in contracting out programs to nongovernmental agencies. Therefore with all these challenges facing health service provision may result to poor service provision to the patients (Sengupta, 2013).

2.3.4 Health Service Provision in Sub Saharan Africa

In Sub-Saharan, Ghana experienced tremendous gains in health from the immediate post Independence era. Life expectancy improved over the years; smallpox has been eradicated; the prevention of a range of communicable diseases such as measles, poliomyelitis, and diphtheria has improved child survival and development. These gains have been due to advances in science, technology and medicine.

Expanded health services based on the principles of primary health care, as well as progress in education and socio-economic development, have also contributed to the gains.

It has made steady progress in the health status of its population over the last decades with life expectancy improving from 50 years at 1960 to 62 years in 2012 (WHO, 2014). Ghana's health system is composed of a variety of facility types and affiliations, ranging from government-owned to private facilities. Approximately one-third of Ghana's health facilities are operated under private ownership, and a 2008 McKinsey study indicated that more than 50% of health service provision in Ghana is delivered by the private sector (Saleh, 2012).

To achieve its mission of improved health and vitality for all Ghanaians, the country has strived to enact policies and implement programs that promote greater access to health services, support the delivery of cost-effective interventions, and equitably provide high-quality care throughout the country. Ghana's expansion of NHIS and its ongoing efforts to maintain coverage serve as a prime example of how the country has prioritized enhancing health system performance (Ghana Statistical Service, 2003).

This Policy places the nation of Ghana efforts within the universal context for health development and plan to provide a comprehensive framework that makes on advancement made in earlier years. The National Health Policy has been designed within the context of Ghana's vision of achieving middle income status by 2015. It places health at the centre of socio-economic development and presents a clear shift in the role of health in the national and international development framework. This is based on the recognition that health is not only a human right issue, but also a key driver of development, and ultimately of wealth creation. The theme of the Health Policy is "Creating Wealth through Health" (MoHAG, 2007).

This health policy of Ghana comes with the following areas to be emphasized; it focuses on the promotion of healthy lifestyles through good nutrition, regular physical exercise, recreation, rest and personal hygiene also further places healthy lifestyles within the context of the physical and social environments where people live, go to school and work; emphasizing potable water, sanitation, and safe food, housing and roads, as means of promoting good health and prevention of diseases and injury. The Policy also seeks to build a pluralistic health service that recognizes allopathic, traditional and alternative providers (both private and public). It also ensures access to quality health interventions for preventing disease and injuries, as well as for restoring the health of the sick and disabled. In that regard, the Policy aims to provide comprehensive health care services comprising preventive, curative and rehabilitative services. Finally, the Policy seeks to promote a vibrant local health industry that supports effective, efficient, and sustainable service delivery, creates jobs and contributes directly to wealth creation and attainment of national development objectives (MoHAG, op cit).

This health policy is guided by the several objectives as follows; To ensure that people live long, healthy and productive lives and reproduce without an increased risk of injury or death To reduce the excessive risk and burden of morbidity, mortality and disability, especially in the poor and marginalized groups To reduce inequalities in access to health, populations and nutrition services and health out (MoHAG, ibid).

The health policy also set out policy measures as follows; by sanctions for constructing new houses without adequate facilities, likewise healthy communities, in collaboration with local government, rural development agencies, community leaders and water and sanitation departments to ensure access to safe water and sanitation by (i) advocating for public-private collaboration and more private provision and financing of waste

management, (ii) scaling-up the WASH (Water, Sanitation and Health) model in deprived communities, and (iii) strengthening the monitoring of water quality, advocating for increased investments in water, and promoting new approaches to water use. Also Healthy schools is emphasized, by collaborating with the MOH, GES and private schools to facilitate the adoption of healthy lifestyles among students through the curriculum, physical education, environmental sanitation and the promotion of healthy eating. moreover healthy working places, by collaborating with the Ministry of Manpower and National Labour Commission to develop and implement programmes on occupational health and safety and Road safety is another policy measure area that can be carried out by strengthening collaboration with the police and DVLA to implement the road safety campaign (MoHAG, ibid).

Also Ensuring food safety is another area that can be achieved by promoting collaboration between FDB, Standards Board, MLGRD and police to develop and enforce standards for the production, storage, sale and handling of food and drink in markets, restaurants and through other vendors. Likewise promote healthy eating programmes in schools and in communities by introducing nutritional education into the school curriculum and by collaborating with caterers, food vendors and restaurants/ 'chop bars' (local restaurants) and media. Set up model regenerative health and nutrition facilities as training centres to facilitate changes in lifestyle (MoHAG, ibid).

Apart from these efforts of Ghana Government of ensuring good health to their people as it is claimed in its national health policy that 'creating wealth through health', health service provision in Ghana still facing problems that needs to be eradicated to smooth health service provision. These problems include the following; lack of appropriate human resources this referred to the lack of specialists for data management, general understaffing of the offices, lack of training, and unmotivated personnel.

Another challenge is delays in salary payments and low levels of these salaries as well as fraud and embezzlement of funds by the staff (Salisu, 2003).

Lack of adequate funding is another most important challenge; financial difficulties were related to high administrative costs and poor revenue generation in the districts, due to the high poverty levels. Also delayed reimbursement of claims is identified as an issue in several regions, especially in the Ashanti, Brong Ahafo, and Western regions (Garrido, 2013).

Likewise corruption in health service provision is claimed to be a challenge. In its 2006 Global Corruption report, Transparency International (TI) "has identified the health sector of Ghana as a corruption prone area with evidence of bribery and fraud across the breadth of medical services. This is said to have emanated from petty thievery and extortion, to massive distortions of health policy and funding, fed by payoffs to officials in the sector" (Ghanaian Chronicle, 2006).

2.3.5 Health Service Provision in Southern Africa

The Republic of Zimbabwe is one among Southern African countries, is a landlocked country of 390,624 km², bounded by South Africa to the south, Botswana to the west, Mozambique to the east and Zambia to the north. Zimbabwe's economy is growing despite continuing political uncertainty.

Following a decade of contraction from 1998 to 2008, Zimbabwe's economy recorded real growth of 6% in 2011. However, the government of Zimbabwe still faces a number of difficult economic problems, including infrastructure and regulatory deficiencies, ongoing indigenization pressure, policy uncertainty, a large external debt burden, and insufficient formal employment (KPMG, 2012).

The Government of Zimbabwe desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organizations and the government, which will allow them to participate fully in the socioeconomic development of the country. This vision will be attained through guaranteeing every Zimbabwean access to comprehensive and effective health services. Extending from this vision, the mission of the Ministry of Health & Child Welfare (MoHCW) is to provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to Zimbabweans while maximizing the use of available resources, in line with the Primary Health Care Approach (GoZ, 2009).

Historically, health service provision in Zimbabwe was provided primarily to cater to colonial administrators and the expatriate, with separate care or second-provision made for Africans. There was no need for legislation to guarantee its provision to the settler community. To address the inequities in health that had existed prior to 1980, at independence, Zimbabwe adopted the concept of Equity in Health and Primary Health Care. Initially, this resulted in the narrowing of the gap between health provision in rural areas and urban areas (Norman, 2010). Over the years, however, there have been clear indications of growing inequities in health provision and health care as a result of mainly Economic Structural Adjustment Policies

(ESAP), 1991–1995, and health policy changes; Infant and child mortality have been worsened by the impact of HIV/AIDS and reduced access to affordable essential health care. For example, life expectancy at birth was 56 in the 1980s, increased to 60 in 1990 and is now about 43. Morbidity (diseases) and mortality (death rates) trends in Zimbabwe show that the population is still affected by the traditional preventable diseases and conditions that include nutritional deficiencies, communicable diseases,

pregnancy and childbirth conditions and the conditions of the new born (Norman, op.cit.).

In order to improve health service provision in Zimbabwe, the Government in 2009 come with the 'National Health Strategy 2009-2013' this strategy identifies universality, equity and quality as central principles in the delivery of health services. The principle of universality calls for measures that ensure that the populations have access to health interventions and services, while the principle of equity calls for measures to close avoidable inequalities in health and in access to the resources for health, allocated in relation to health need. Thus, closing inequalities in health call for action on the social determinants of health (TARSC, 2013).

To enable effective and efficient implementation of this strategy the government of Zimbabwe through the Ministry of Health and Child Welfare has identified the critical success factors for the successful scaling up of health programmes. There must be provision of adequate, skilled and well remunerated human resources for health.

Efforts will be made to; retain health workers at work by giving them a living income that can be sustained by the current economy also will increase productivity and professionalism of health workers by providing them with adequate tools of the trade, likewise will intend to reduce the overall vacancy levels through halting and reversing brain drain, recruiting, training and retaining qualified health staff (GoZ, 2009).

The role played by community health workers, as evidenced by their actions during the cholera epidemic, should not be underplayed as one looks at the human resources for health. This will be continuous supply of medicines and medical supplies; there will be need to improve the availability of medicines, medical sundries and other hospital supplies, to a level that will enable institutions to provide at least basic services as

defined for each level of care. Thirdly is provision of functional Equipment (Fixed and movable) and Infrastructure: - There will be need to improve the availability and functionality of diagnostic and treatment medical equipment in critical departments (Theatre, Laboratory, Casualty, Maternity, Xray & renal departments). Water supplies and provision of generators at health facilities shall be given high priority. Fourthly is provision of Transport:- There will be need to improve the availability of reliable transportation and telecommunication systems to improve and strengthen the referral system. Fifthly is ensuring a sustainable and predictable financial base, likewise there will be a need for advocating and lobbying for a sustainable and predictable financial resource base, to ensure the provision of high quality services to the population. And lastly there will also be need to address the issues of leadership and governance at all levels, disease surveillance and health information for decision making including strengthening coordination of health sector players (GoZ, 2009).

Another effort to improve health service provision was Participation of communities, of both organized and unorganized public groups, is widely argued to be an important factor in improving health outcomes and the performance of health systems. Despite this, and the common inclusion of 'participation' as both means and ends in health policy, participation is poorly operationalzed, both in governance and accountability in health and in technical health interventions, so that there is little systematic analysis of its specific contribution to health and health systems outcomes (Loewenson, 1998).

Despite the efforts the Government of Zimbabwe to improve health services provision to its people still health service provision in Zimbabwe facing bottlenecks that hindered people of Zimbabwe to enjoy quality health services particularly from public institutions, these bottlenecks are; Political violence; due to political violence health experts such as doctors, nurses, pharmacist and others migrates to other countries

looking for conducive environment for their full utilization their knowledge leaving the country with lack of human resources in health sector (KPMG International Cooperation, 2012).

Also there is widespread corruption in government and lacks transparency. In 2005, the government enacted an Anti-Corruption Act that established a government-appointed Anti-Corruption Commission to investigate corruption; however, it includes no members from civil society or the private sector. The government prosecutes individuals selectively, focusing on those who have fallen out of favour with ZANU-PF and ignoring transgressions by members of the favoured elite.

The coalition government formed in February 2009 enhanced the institutional capacity of the Anti-Corruption Commission, with members appointed from civil society and the private sector. Moreover, the government has improved accountability in the use of state resources through the introduction of the Public Finance Management Act in March 2010 (KPMG, op.cit). With all these efforts corruption practice could have stopped. But in many government's operations including in provision of health services corruptions practice and lack of transparency exists.

Besides lack public of participation; Participation of communities is widely argued to be an important factor in improving health outcomes and the performance of health systems by creating realistic expectations between communities and health services in their contributions towards health, and in the governance of health system. Various examples are outlined of the relationship between social participation and control and health outcomes. It argues for a wider inclusion of social groups from civil society, elected leadership and health systems in structures and processes that set and audit health policies and priorities (Loewenson, (1998).

Despite this, and the common inclusion of 'participation' as both means or ends in health policy, participation is poorly conceptualised and operationalised, both in governance in health and in technical health interventions, undermining systematic analysis of its specific contribution to health and health systems outcomes (Loewenson, op.cit.). All these weakened the efforts of the government of Zimbabwe to provide quality health services to its people despite all efforts to improve health services provision.

Botswana is also another country located in the southern part of Africa, is a landlocked country situated in the centre of southern Africa, sharing borders with South Africa (to the south and east), Namibia (west), Zimbabwe and Zambia (north). It is a semi-arid country of 581,730 square kilometres (sq km). Okavango River from Angola flows through Botswana creating the Okavango Delta (swamp) in the Okavango District. The Delta fills Lake Ngami and Thamalakane River in Ngamiland and Chobe River in the Chobe District. The most common natural hazards include drought, floods and veldt fires (RoB, 2010).

Botswana has a total Gross Domestic Product of BWP 24.6 billion, representing a GDP per capita of BWP 14,232 (at the 1993/94 constant prices) for the year 2009/10. The composition of the GDP by sector is agriculture 1.8%, industry 59.5% (including 41.1% mining) and services 35.2%. However, due to the skewed distribution of wealth, 28% (UNDP 2007) of the total population live on less than a dollar-a-day. This disproportional distribution with the existence of poverty and unemployment may lead to alcohol and substance abuse which impact negatively on the overall health status of the people. It is a challenge for the health system to ensure universal access to quality promotive, preventive, curative and rehabilitative health services among the economically disadvantaged people.

The life expectancy at birth in Botswana is estimated at 54.4 years (48.8 males: and 60 females). The crude birth and crude death rates were estimated at 29.7 and 11.2 per 1000 respectively while infant and under-five mortality rates were 57 and 76 per 1000 live births respectively. The Maternal Mortality Ratio (MMR) is 193 per hundred thousand live births based on the CSO 2007 calculations. A total of 25.9% of the population are stunted, of which 16.8% are moderately stunted and 9.1% severely stunted (RoB, 2011).

The overall guiding document for national development in Botswana is Vision 2016, a broad based national approach adopted in 1996 focusing on aspiration of the Nation.

The principles and objectives of Vision 2016 guide the formulation and implementation of revolving 6-year National Development Plans (NDP). In pursuit of the Vision 2016, health related goals are set which contribute to the national development of Botswana, mainly through one of the pillars 'A compassionate, just and caring nation' (RoB, 2011).

Health service delivery in the country is pluralistic. There are public, private for-profit, private non-profit and traditional medicine practices. The MOH is mandated with overall oversight and delivery of health services; it is responsible for the formulation of policies, regulation and norms, and standards and guidelines for health services. Recent reorganization and the relocation of primary health care from the Ministry of Local Government (MLG) to the MOH makes the MOH the main public sector health care provider. This move has been made with a view to increase efficiency and also to provide a continuum of care (RoB, 2011).

In order to improve access to quality health care, the Government of Botswana formulated National Health Policies and the last policy formulated in 2011.

This National Health Policy bears the slogan of 'Towards a Healthier Botswana' implying that the provision of health services is not just mere curing the sick but also to promoting healthy lifestyle in order to prevent diseases/ill-conditions for all people living in Botswana. The Policy also covers all the six building blocks of health systems with specific direction for each of them. It also provides the platform for well coordinated planning, financing, monitoring and evaluation. The Policy will also be implemented through an Integrated Health Sector Plan which will incorporate not just public sector's effort but also those of the Non-Government Organisations, Community Based Organizations and private sector (RoB, 2011).

Apart from these collective efforts to ensure smooth provision of health service provision, health sector in Botswana still facing challenge as follows; A shortage of trained and qualified staff remains one of the major bottlenecks towards the availability of quality health care in Botswana. Shortage of trained and qualified staff remains one of the major bottlenecks towards the availability of quality health care in Botswana. There are also increasing demands on the already over-stretched skilled workforce as a result of the additional programmes and projects, in particular those related to HIV/AIDS. Although the rate of attrition is negligible, there is high turnover of staff at all levels of the health sector (RoB, 2011).

Another challenge facing health service provision in Botswana is corruption; Corruption impedes and robs the organization's ability to perform effectively and efficiently since it consumes and depletes the scarce resources. It affects the dignity and reputation of individuals, organizations and the nation at large. All individuals and organizations therefore need to commit to fighting this ill behavior. Organizations have a responsibility to ensure that services are available and accessible to nationals in a transparent and equitable manner (RoB, 2013).

To combat it the government of Botswana though the Ministry of Health formulated the ant corruption policy on health service provision with the aim to combat and prevent corruption practice in health service provision. As it claimed that "The Ministry of Health, like most of the government organizations and parastatals has been a source of discourse on the rampant corruption that bedevils the public system.

The Ministry has been inundated with allegations of inflated contracts, unsupervised and poor service delivery, and collusion to defraud government with significant public resources diverted for personal gain, to name but a few.

This policy highlights necessary steps that need to be taken to ensure that Code of Conducts and other guidelines are followed by all staff in different positions and levels of responsibility, committing themselves to principles of incorruptibility, integrity, openness and respect" (Gamester, 2013).

With the presence of this policy one may believe that once the policy has been effectively implemented, health service recipient will enjoy an efficient and effective quality health services; as well as public confidence and trust in the health system will be revealed. However the problem of corruption in service delivery particularly in health service persist that lead to deprive of some patients from having quality health services (Beileh, 2009).

2.3.6 Health Service Provision in East Africa

The Health Sector Strategic focus in Kenya is guided by the overall Vision 2030 that aims to transform Kenya into a globally competitive and prosperous country with a high quality of life by 2030" through transforming the country from a third world country into an industrialized, middle income country. Its actions are grounded in the principles of the 2010 constitution, specifically aiming to attain the right to health, and

to decentralize health services management through a devolved system of Governance. This strategic focus has been defined in the Kenya Health Policy, which has elaborated the long term policy directions the Country intends to achieve in pursuit of the imperatives of the Vision 2030, and the 2010 constitution (RoK, 2010).

In Kenya, Health services are provided through a network of over 4,700 health facilities countrywide, with the public sector system accounting for about 51 percent of these facilities.

The public health sector consists of the following levels of health facilities: national referral hospitals, provincial general hospitals, district hospitals, health centers, and dispensaries. Health services are integrated as one goes down the hierarchy of health structure from the national level to the provincial and district levels (RoK, 2011).

The government health service is supplemented by privately owned and operated hospitals and clinics and faith-based organizations‟ hospitals and clinics, which together provide between 30 and 40 percent of the hospital beds in Kenya (RoK, 2010). Depending on their comparative advantage, Non Governmental Organizations, Faith Based Organizations and community-based organizations (CBOs) undertake specific health services (Murkomen, 2012.).

The Kenya Health Policy, 2012 – 2030 gives directions to ensure significant improvement in overall status health in Kenya in line with the country's long term development agenda, Vision 2030, the Constitution of Kenya 2010 and global commitments. It demonstrates the health sector's commitment, under government stewardship, to ensuring that the Country attains the highest possible standards of health, in a manner responsive to the needs of the population (RoK, 2010).

The overall objective of this Policy is to attain universal coverage of critical services that positively contribute to the realization of the overall policy goal. And have six policy objectives which address the current situation and each with specific strategies as follows; the first objective is to Eliminate communicable conditions, this aims to reduce the burden of communicable diseases, till they are not a major public health concern.

The priority policy strategies include: Attain universal access through preventive health services addressing major causes of the disease burden due to communicable conditions, to ensure quality of care in provision of the preventive and promotive services addressing major causes of the burden due to communicable conditions; Put in place interventions, also directly addressing marginalized and indigent populations affected by communicable conditions; and enhance comprehensive control of communicable diseases by designing and applying integrated health service provision tools, mechanisms and processes (RoK, 2010).

Policy Objective two: is to Halt and reverse the rising burden of non communicable conditions; this is to be achieved by implementing strategies to address all the identified non communicable conditions in the country. The priority policy strategies include: **e**nsure universal access to interventions addressing recognized non communicable conditions in the country; Ensure that services relating to non-communicable conditions are of high quality standards with a view to maximize utilization of services the population has access to; Strengthen advocacy for health promoting activities aimed at preventing increased burden due to non-communicable conditions; Put in place programs for non-communicable diseases prevention and control; Put in place interventions directly addressing marginalized and indigent populations affected by no communicable conditions;

Design and implement integrated health services provision tools, mechanisms and processes with a view to enhance comprehensive control of non communicable diseases; Decentralize screening for non-communicable diseases to the lower levels to increase access (RoK, 2010).

Policy Objective 3: Reduce the burden of violence and injuries; this will be achieved by putting in place strategies to address the causes of injuries and violence. The priority policy strategies include the following: Make available corrective and inter-sectoral preventive interventions to address causes of injuries and violence; Ensure universal access to quality emergency care (curative and rehabilitative) that mitigates effects of injuries and violence; Put in place interventions directly addressing marginalized and indigent populations affected by injuries and violence; Scale up physical and psychosocial rehabilitation services to address long term effects of violence and injuries (RoK, 2010).

Policy Objective 4: Provide essential health care; these shall be affordable, equitable, accessible and responsive to client's needs. This will be achieved by strengthening the planning and monitoring processes relating to health care provision to ensure that demand driven priorities are efficiently and effectively implemented. The priority policy strategies to achieve this are: Scale up physical access to person-centered health care by prioritizing solutions targeting hard to reach, or vulnerable populations; Ensure provision of quality health care, as defined in the norms and standards and guidelines, and by users; Ensure free access to trauma care, critical care, emergency care and disaster care services; Promote medical tourism as a means to ensure availability of high quality care in the country (RoK, 2010).

Policy Objective 5: Minimize exposure to health risk factors; this will be achieved by strengthening the health promoting interventions, which address risk factors to health, and facilitating use of products and services that lead to healthy behaviors in the population.

At the beginning of the policy period, the key policy strategies that will be employed to achieve these include: Reduce unsafe sexual practices, particularly amongst high risk groups; Mitigate the negative health, social and economic impact resulting from the excessive consumption and adulteration of alcoholic products; Reduce the prevalence of tobacco use and exposure to tobacco smoke and other harmful addictive substances; Institute population-based, multisectoral, multidisciplinary, and culturally relevant approaches to promoting physical activity; Strengthen mechanisms for screening and management of conditions arising from health risk factors at all levels; Increase collaboration with research based organizations and institutions (RoK, 2010).

Policy Objective 6: Strengthen collaboration with other sectors that have an impact on health; This will be achieved by adopting a 'Health in all Policies' approach, which ensures the Health Sector interacts with and influences design, implementation and monitoring of interventions in all sectors that have an impact on health. As such, the social determinants of health that the Policy will seek to influence include: women literacy, access to safe water and adequate sanitation, nutrition, safe housing, occupational hazards, road safety, security, income among others (RoK, 2010).

The level of involvement of the health sector shall depend on the level of impact on health. Key areas that the health sector will seek to influence in this regard include the following: Economic growth and employment: ensure that work and stable employment and entrepreneurship opportunities are available for all people;

Security and justice: ensure enhanced security and fair justice system important in managing access to food, water and sanitation, housing, employment opportunities, and other determinants of wellbeing; education and early life: enhance education of both women and men to promote their abilities to address challenges relating to health; Agriculture and food: promote considerations of safety in food production systems, manufacturing, marketing and distribution; Nutrition: ensure adequate nutrition for the whole population through promotion of proper nutrition practices; Infrastructure, planning and transport: encourage proper planning of roads, transport system and housing with a view to facilitate movements of people, goods and service (Murkomen, 2012).

Environments and sustainability influence population consumption patterns of natural resources in a manner that minimizes adverse impact on health; Housing: promote housing designs and infrastructure planning that take into account health and wellbeing; Land and culture: strengthen and access to land and other culturally important resources by particularly women; Population: manage population growth and urbanization implications (Thaxton, 2007).

The government of Kenya underscores the importance of affordable and equitable health care systems in realization of the set social goals. However efforts of the Government of Kenya to improve and maintain smooth health service provision to its people is hindered by various challenges such as corruption, communication barrier due to the use of more than one language and lack of adequate number of high skilled and experienced employees (Wanjau, 2012).

2.3.7 National Health Policy of Tanzania of 2007

The Tanzania health policy vision is to improve the health and well being of all Tanzanians with a focus on those at most risk and to encourage the health system to be more responsive to the needs of the people (URT, 2007).

The National Health Policy focuses on rreducing the burden of disease, maternal and infant mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions. Besides, it ensures that the health services are available and accessible to all people wherever they are in the country whether in urban or rural areas. Moreover, this policy deals with training and provides competent and adequate number of health staff to manage health services with gender perspective at all levels. Capacity building of human resources at all levels in management and health services provision will be the ultimate goal of the Government (URT, 2007).

Likewise, it sensitizes the community on common preventable health problems; improve the capabilities at all levels of society to assess and to analyze problems and to design appropriate action through genuine community involvement including community health financing and promoting awareness in government and the community at large that, health problems can only be adequately solved through multi-sectoral cooperation, involving other sectors (URT, 2007).

Eventually, the policy creates awareness through family health promotion that the responsibility for once health rests squarely with the individuals as an integral part of the family, community and the nation.

Promote and sustain public private partnership in the delivery of health services and also promotes traditional medicine and alternative systems of healing (URT, 2007).

Therefore in order for the government of Tanzania and other health stakeholders to implement national health policy efficiently there is need to have health service providers that are free from corruption environments.

In recent years, cause and impacts of corruption gained attention from development economists as well as international financial institutions and policymakers due its detrimental effects (Akçay, 2006). Corruption in African countries is considered by most observers to be a major impediment to growth (Knuckles, 2006).

In Sub-Saharan Africa along with East and Central Africa particularly direct factors for corruption include regulations and authorizations, decisions over expenditures, provision of goods and services below market prices and quality, inflation and income inequality, on the other hand, quality of bureaucracy, level of public sector wages, penalty systems and transparency of rules, laws, and processes are the indirect factors that promote corruption (Robert, 2012). Corruption slows down the wheels of business and commerce as a result, it impedes economic growth and misallocation of resources, as it enhances inflation, reduces expenditures for education and health, distorts markets, increases income inequality and poverty, and reduces tax revenue (Khan, 2012).

Also SIKIKA (formerly known as Youth Action Volunteers a non-governmental organization established in 1999,implementing activities aimed at improving governance and citizen participation in the health sector in Tanzania conducted a research on corruption in health services in Dar es Salaam and Coast Region the result of this study showed that the factors of corruption in health services to be: inadequate remuneration for health workers, health workers not adhering to professional ethics,

patients prompting health workers to take bribes because of uncertainty of getting good quality health care, scarcity of equipment and reagents for such services as x-ray, ultrasound (Muhondwa, 2010).

The government of Tanzania in order to improve salaries and other incentives to health staff as many research identified to be a major factor for corruption in health service provision among other things reviewed salary scheme for health in 2009 where health staff paid special scale compared to other government staff (URT, 2009) In 2012 the government also reviewed on call allowances in order to improve rates of payment with expectation that will motivate health workers and prevent them from corruption practice (URT, 2012).

2.3.8 The Fight against Corruption in Tanzania

Efforts to combat corruption in Tanzania started during colonial period under the British colonialism. British Colonialists established Punishment Corruption Act (PCA) that used to punish corruption offenders whenever criminals were proved to commit such a crime. Despite these efforts done by colonialists, but corruption practices continued to prevail even after independence. After independence, the government of the united republic of Tanzania made several efforts in trying to address and redress the problem of corruption. Such efforts include; issuing and amending code of ethics and conduct for public services, Public Leadership Code of Ethics Number 13 of 1995 and Establishment of Prevention and Combat of Corruption Act No.11 of 2007 with the major objective of promotion and enhancement of good government and eradication of corruption. (PCCB Report, April 2013). Likewise "The Second Phase of the National Anti-Corruption Strategy and Action Plan (NACSAP II) was officially launched by the government of Tanzania on December 10, 2006, which was to be implemented in

2008– 2011, with the aims to build on the achievements of NACSAP I and address challenges encountered by becoming more focused, robust, relevant and inclusive.

In collaboration with other anti-corruption stakeholders, the programme aimed at helping to set up, organize, and mainstream a sustainable mechanism and responses against corruption with United Nations Development Programme (UNDP) as the main funding and technical partner. NACSAP II also aims at complementing and integrating anti corruption measures into the core public sector reforms such as Public Sector Reform Programme (PSRP), Legal Sector Reform Programme (LSRP), Local Government Reform Programme (LGRP), and Public Financial Management Reform Programme (PFMRP) in strengthening and instituting good governance, transparency, accountability, integrity, efficiency and improved public service delivery (URT, 2008).

2.4 Research Gap

From the review of literature, it is noted that many researcher and government efforts to combat corruption made, most of them based on inadequate remuneration for health workers, health workers not adhering to professional ethics, patients prompting health workers to take bribes because of uncertainty of getting good quality health care as major factors influencing corruption in health service provision. Also effects of corruption in health service provision exhausted, however little has been written on internal institution control. Therefore, the study focused on internal institutional control if there is weakness in providing health services may influence corruption practice to health staff.

2.5 Conceptual Framework

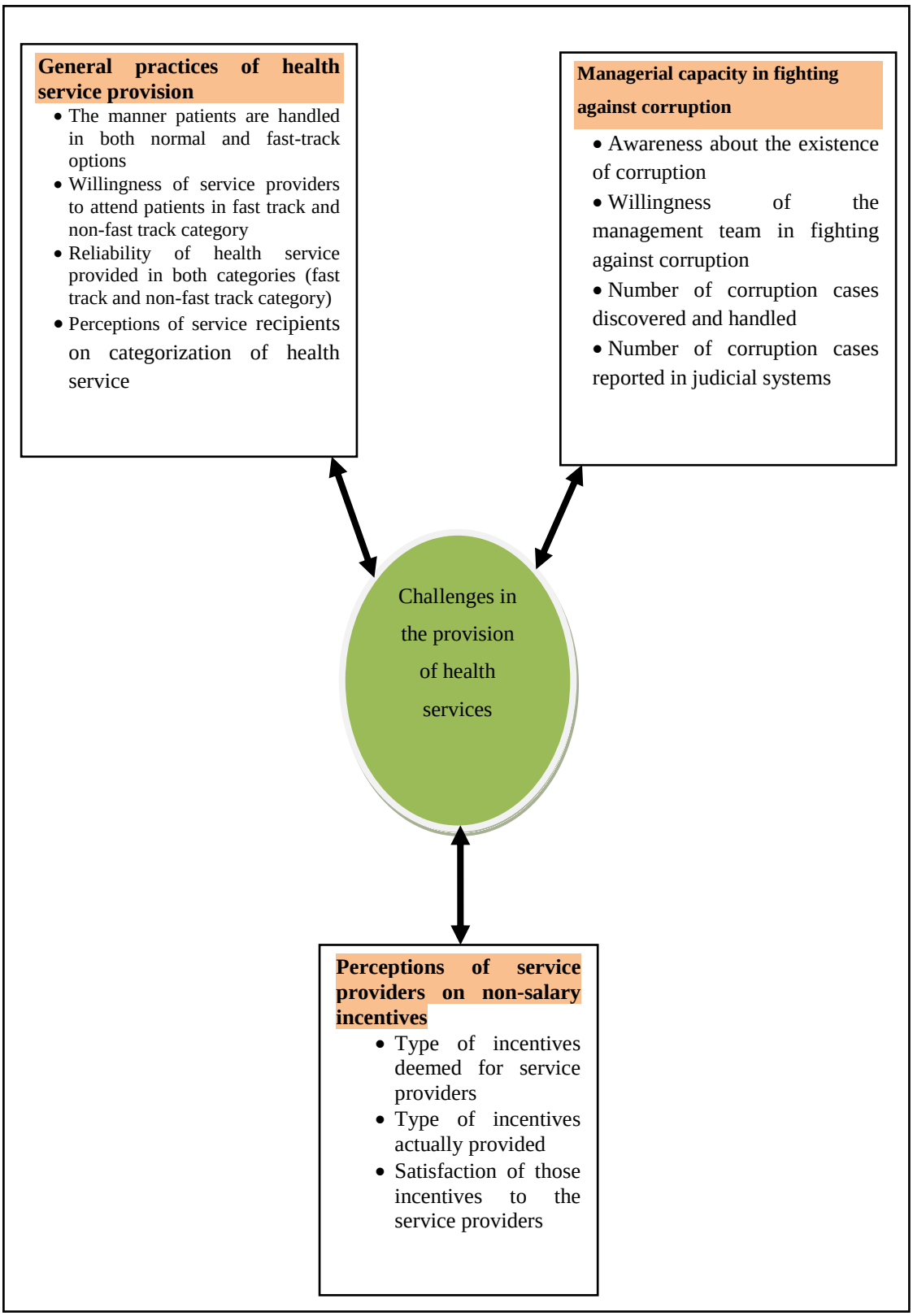
This study has conceptualized the problem of corruption in health service delivery such that, it is caused by three major factors namely introduction of a fast track system,

which has brought differential treatment among patients; managerial capacity in fighting against corruption and the perceptions of health service providers on the non-salary incentives they receive from the government.

Introduction of the fast track system, is suspected to influence corruption because it probes service providers to provide differential treatment to the patients such that they favour and prioritize those patients using fast track option (since they provide more money, part of which is directly given to the service providers), while providing less quality service to the patients using non-fast track option since they provide little money which goes directly to the hospital, and not on the hands of individual service providers.

In management capacity, this study conceptualizes that; preventing corruption requires the management team, which is willing and capable of preventing it. The evidence of this can be shown in the number of corruption cases discovered and reported to the judicial systems where justice is determined and executed. The conceptualization of the perception of service providers on incentive provided is based on the conception that; if they perceive that the incentives provided are insufficient, it is more likely that they will get involved in corruption cases and vice versa. The Figure 2.1 presents the conceptual relation between persistence of corruption and its influencing factors.

Figure2.1: Conceptual Framework



Source: Research Own Construct, 2015

2.6 Summary

The Chapter focused on the connected literature, introduction of it, definition of key terms, theoretical literature review, conceptual framework, analytical review, critical review, empirical review, research gap as well as conclusion of the chapter.

The subsequently chapter, (Chapter three) research methodology focused on the research design; description of study area, sampling method and sample size, method and techniques of data collection, sources of data as well as data analysis and interpretation.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Discussed earlier was chapter two concerning with the literature review. The next chapter (Chapter III) discuses about the methods used in the study. It begins by presenting the descriptions of research design then the study area, followed by presenting the research design and case study. Further, the research sample and the sampling criteria used to identify the participants of the study are discussed. Thereafter, the chapter presents the data collection procedures, data collection methods and data analysis. The chapter winds up with a section on validity reliability ends up with the chapter summary.

3.1 Location of the Study Area

Due to the nature of the study and time constraints a case study was useful strategy to be adopted. A case study is the strategy in which the researcher in social science can conduct in-depth investigation of an individual, group, institution or phenomenon. It save both time and cost and it is flexible in data collection method (Kothari, 2004). The case study method was used to select Dodoma Regional Referral Hospital in Dodoma Region. Dodoma Regional Referral Hospital is situated in Dodoma town which has a population of approximately 441,000 and is the capital city of Region. Dodoma town is the official seat of the Tanzanian Government, the United Republic Parliament and the ruling party and it is situated at the road and Railway crossings to many regions and neighboring countries. It is a dry port and it is turning into an academic town due to increasing colleges and student population.

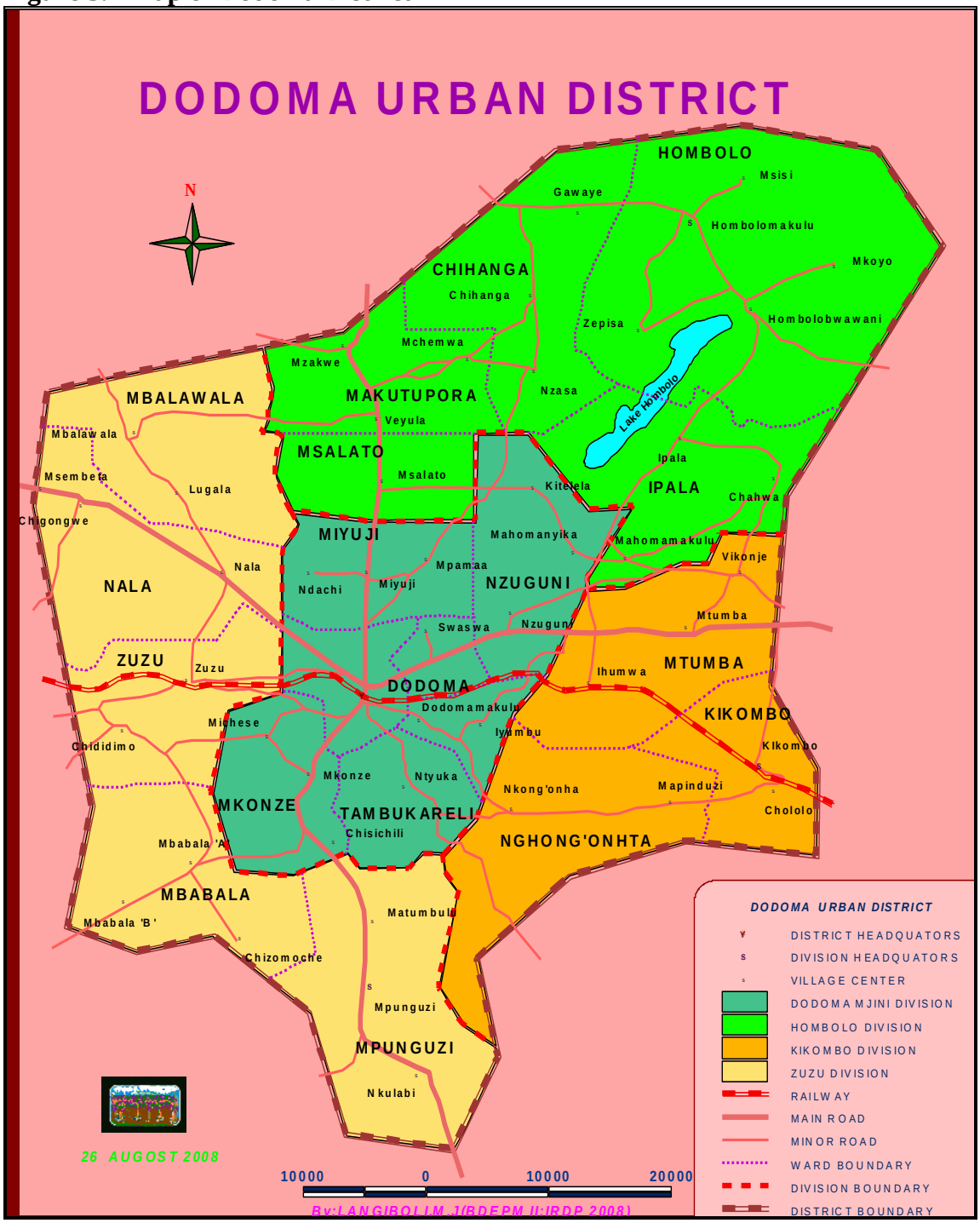
Dodoma Regional Referral Hospital serves over 2 million residents of Dodoma Region as well as other people from neighboring districts of Kiteto (Manyara Region), Manyoni (Singida Region) and Gairo (Morogoro Region (RMO, 2014). Dodoma Regional Hospital was constructed in 1929 as a centre for casualties who were injured during the construction of the Railway. It was then upgraded to health centre and finally to a Regional Hospital. This hospital is located in the Dodoma Municipality and has a bed capacity of 420 (RMO, 2014).

The outpatient department has 35 rooms including specialized clinics, on average 300 outpatients are attended per day in this department. The average number of patients who are admitted everyday is 42 and the average bed occupancy rate is 83%. The length of hospital stay ranges between 4 to 5 days. About 3,275 operations are performed in a year. The current number of staff is 525 this includes specialists, Medical Officers, Dental Officer, Assistant Medical Officers, Assistant Dental Officer and Clinical Officers. Furthermore we have Nursing Officers, Enrolled Nurses and Medical Attendants.

Being a referral hospital, this hospital is also used as a students' prccticing centre for students from various colleges including University of Dodoma, St. John's University, Mvumi Nursing School and Clinical Officers' college, Singida Laboratory assistants' college and KCMC Physiotherapy unit. Departments include Internal Medicine, Paediatrics, General Surgery, Orthopaedic Surgery and Orthopaedic workshop, Obstetrics and Gynaecology, Dental Clinic, Opthalmology, Physiotherapy, and Radiology. Others are Pharmacy, Laboratory, TB and Leprosy unit, Environmental health and Sanitation unit, Laundry and Mortuary. There is a special clinic for Care and Treatment of People Living with HIV/AIDS.

Therefore this health service facility was selected to represent other health facilities in the region because is determined to be a referral hospital in the region receiving patients from the region and outside the region, also it provides various health services that cannot be found in other health service providers in the region as shown above.

Figure 3.1 Map of Dodoma District



Source: Dodoma Urban Profile, 2015

3.2 Research Design

A research design is the framework for a study that specifies how each activity should be conducted to accomplish the research objectives, which includes specifying the information required, designing the instruments, selecting the sample, collecting and analyzing the data (Robson, 2002). Research design must be governed by the notion of the fitness for purpose (Cohen *et al.,* 2000). It refers to the structure or plan of research, what to do and how to do it. It involves the structuring of variables in the manner that enable their relationship to be determined by the study (Cohen *et al.,* 2005).

A cross-sectional research design was applied in this study; the cross-sectional research design allows data to be collected at single point in the one time and used in descriptive study and for determination of relationship of variables. (Bailey, 1998: Babbie, 1990). Descriptive research approach was intended to gained more information about the nature of a particular area of study. This approach therefore used to provide a picture of a situation so as to identify the problems (Burns and Grove 1999) the main purpose of descriptive research was to provide a description on the state of affairs as it exists at present or a give n time (Kothari, 2005).

3.3 Research Approach

Qualitative and qualitative approach was used during the study although in very few cases such as computation of percentages and tabulations, quantitative approach was employed. The qualitative research approach includes a range of methods such as documentary analysis, interviews and observations (Maxwell, 2012). The qualitative research approach was used because the approach gives an opportunity for one aspect of a problem to be studied in depth and it enables the researcher to collect facts and study their relationship in order to find sources as well as solutions for the problem.

Furthermore, qualitative research approach enables the researcher to be in a direct contact with respondents. Qualitative research approach has enhanced learning whereby the researcher and respondents have been interacting in a special manner in order to accomplish the already formulated goals.

In the light of this, the qualitative approach has enabled the researcher to assess provision of health services in government hospitals specifically in Dodoma regional referral hospital. Marshall *et al.*, (2011) recommended the use of qualitative approach when doing research due to its flexibility in data collection and research plan. The approach allows the use of different methods such as in-depth interviews and observations in order to achieve objectives of the study. The approach is dynamic and also allows the use of documentary analysis to establish as well as to facilitate the relevancy of the study. According to Marshall, (2014) flexibility in procurement context allows day-to-day correction of the problems arising during the study and consequently, the structure of the study has been amended as the study proceeds.

Polit & Beck, (2010) addressed the importance of using qualitative approach when doing research that it allows the researcher to gather authentic data which are very easy to analyze. He continues to recommend on the use of this type of approach because it gives the context of the experience, states the intension and meanings that argued in experience and reveals experience as a process.

Furthermore; quantitative research were used as the defining factor, in that numbers result from the process, whether the initial data collection produced numerical values, or whether non numerical values were subsequently converted to numbers as part of the analysis process, as in content analysis (Cohen *et al.*, 2007).

3.4 Sampling Design

According to Babbie, (2001), *"Sampling design"* refers to the procedure used in drawing the sample from the list of population elements. This study was employed purposive and accidental sampling techniques in drawing a sample where information was collected. Purposive sampling was used to select some health service providers whom the research believes that they have to provide enough information relevant to the study. Accidental sampling is the sampling technique, which is used in collecting data in a place where it is difficult to establish the population size and respondents can hardly be traced (Bartlett *et al.,* 2001). Accidental sampling was chosen by this study, because the population of patients attending the hospital per day could not easily be established.

3.4.1 Sampling Frame

Babbie (2001) defines sampling frame as a list of elements in the population from which a sample is drawn. Study populations may be defined by geographic location, age, sex, with additional definitions of attributes and variables such as occupation, religion and ethnic group (Banerjee and Chaudhury, 2010). In this study, the list of health service providers in Dodoma Regional Referral Hospital was a sampling frame from which the samples were drawn.

3.5 Sample Size

Sample size refers to the number of elements chosen from the population and from where information about the study can be obtained (Bartlett, 2001). This study include 90 respondents in which 50 were health services providers and 40 were health services recipients.

In addition, Yin (1994) and Yomane, (1967) argue that, 5%-10% is the best confidence interval to be used in studying social issues. In this study, 10% confidence interval was used to calculate the sample health service providers as shown below:

$n = N/ (1+Ne^2)$

Whereby;

N = population size/estimated population size

n = sample size

e = confidence interval (10 percent)

Given N=825(525 Regional Referral Hospital employees and 300 an average of patients treated per day).

$n = 825/ [1+825(0.1)^2]$

n = 825/9.25

n = 89.1≈ 90 respondents.

3.6 Data Types and Sources

Both primary and secondary data were collected from primary and secondary sources respectively. Primary data are the first hand information which are collected by a researcher directly from the respondents through interview and observation, survey methods (Kothari, 2004). Primary data was collected from patients and some selected health service providers from Dodoma general hospital; while secondary data was collected from books, PCCB reports, medical reports in the hospital, health policy, and from other sources like the internet.

3.7 Data Collection Methods

Data was collected by using social survey, personal interview and observation as methods for data collection whereas interview guide, questionnaire was used as data.

Interview is the method of data collection, which involves presentation of oral-verbal stimuli and reply in terms of oral-verbal responses; and it can be used through personal interviews and, if possible, through telephone interviews (Kothari, 2004). Observation is another method of data collection which involves systematic looking and recording of important observable data which are useful to the research study (Kothari, op.cit.).

3.8 Data Analysis

Data analysis is a general way that involves a number of closely related operations which are performed with the purpose of summarizing the collected data and organizing them in such a manner that they answer the research questions or computation of certain indices or measures along with searching for patterns of relationships that exist among the data groups (Kothari, 2004). Data analysis can be categorized into qualitative analysis and quantitative analysis. This study employed both types of analysis. Quantitative data were analyzed through the use of simple counts, use of tables in frequency and percentages. Qualitative data were analyzed through the application of pattern matching, strong explanation building, comparison of data and information as proposed by Yin, (1994).

Data collected were analyzed by using Statistical Package for Social Sciences (SPSS Version 21) where descriptive and inferential statistics were conducted. Descriptive statistical analysis was involved to measure of central tendency such as means, standard deviation, frequencies, and percentages; while in the inferential statistics, chi-square, and paired t-test were used in data analysis. Chi-square test was used to analyse the association of responses given between recipients of health service from fast track and those receiving non-fast track service in the hospital, while paired t-test was used to check the differences in the services provided through fast track and non fast track health service.

3.9 Validity and Reliability of Study Findings

To ensure quality and acceptability of mixed studies (Onwuegbuzie, 2006) argue that it is important to seek the way to compensate the weaknesses of one method with the strengths of another method. There are various techniques employed by field researchers in ensuring their studies are of quality or authentic. Use of such techniques depends upon the dominance of the qualitative or quantitative method and type of data analysis used within the project (Brannen, 2005). Given that this study was predominantly qualitative, it proposed to use of (Lincoln, 1985) concepts such as truth of the findings, high degree of neutrality from the researcher in analyzing and reporting findings of a study as were given and shaped by the respondents. To ensure validity of data collected; in depth interview was conducted with respect to interview guideline to ensure that respondents were clearly informed about the purpose of the study and the procedure to be carried out was also presented to the respondents. Also respondents assured on confidentiality and were emphasized to provide right answers. Also since respondents were assured on confidentiality and aware about the purpose of the study were provided reliable information.

3.10 Ethical Issues

The terms ethics and morality are closely related. Often refer to ethical judgments or ethical principles where it once would have been more common to speak of moral judgments or moral principles. These applications are an extension of the meaning of ethics. Strictly speaking, however, the term refers not to morality itself but to the field of study, or branch of inquiry, that has morality as its subject matter. In this sense, ethics is equivalent to moral philosophy (Encyclopedia Britanica, 2007).

In this study all ethical issues were observed by following all procedures required in data collection and process of obtaining relevant authority concern. The study has taken in to consideration all ethical issues by following truthfulness, thoroughness, objectivity and relevance principles as both were applied in all procedure required in planning, conducting and reporting the results. All these applied to reflect principles ethics in research.

3.11 Summary

Discussion in this chapter has been the research methodology for the study. It has presented the research design based on the ethno methodological and mixed methods approaches. While due to its embedment in the ethno methodological approach the study makes use of the case study, it collects quantitative and qualitative data, on the one hand, and were analyzed the data with the use of statistics and content analysis, on the other hand. The chapter has winded up with the issues related to validity and reliability as well as research ethics.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter mainly concerns with data presentation, analysis and discussion of the findings. Data were analyzed both quantitatively and qualitatively. The quantitative data were summarized in tables and figures. The analysis meant to show relationships among various research variables. The quantitative data were supported in some cases with respondents' views, opinions, feelings and experiences (qualitative data) gathered through interview method. Is narrates the study results and the discussion on each of the study results. The part is further subdivided into 4 sections which reflect the main variables. These subsections are preceded by the description of the respondents' characteristics which is aimed at describing the kind of respondents who were consulted by this study.

4.1 Social-Demographic Profile of the Study Population

This study consulted a total of 90 respondents from whom primary data were collected, among which 40 were the recipients of health service and 50 were the health service providers. The characteristics described in this section include respondents' gender distribution, education levels, age groups, and occupation. Each of these characteristics is described in relation to the study purpose.

4.1.1 Gender Distribution of the Respondents

The aim of looking on the gender distribution is based on roles and relationships between men and women in the specific population.

Gender perspective created unique social roles and relation between women and men. The role of male and female in the society differ from one society to another. It is claimed that cultural norms creates gap between men and women in various roles in the society (Belafonte, 2006). In relation to health service provision nurses and medical attendants carders has a great number compared to other carders like doctors and health technologists and historically most of nurses and medical attendants are women. From the study, women have a big role compared to men that‘s means women played great role in health service provision in health service facilities. Table 4.1 present findings concerning respondent’s age.

Table 4.1: Gender of Respondents

Gender	Frequency	Percent
Gender of Recipients Respondents		
Male	13	26
Female	37	74
Total	**50**	**100.0**

Source: Field Data Survey, 2015

Respondents composition was comprised of 37(74%) women and 13(26%) men of health service providers and on the side of health service recipients 24(60%) were women and 16(40%) were men this is caused by the fact that life expectance for women is longer than men as it is claimed that; Women live is longer than men, an average of 5 years longer, but they tend to be “sicker” than men (Waldron, 1994). Hence large group of service recipients in Dodoma Regional Referral Hospital is women. It is claimed that underinvestment in female education, for example, contributes to stereotypes about women’s relative intelligence and skills, regardless of those possessed by the individual women (Permanyer, 2013).

This hindered women to access higher education compared to men that can facilitate them to acquire higher post in public organization including in health facilities like medical specialists or technologists.

4.1.2 Education Status of the Staff Respondents

The distribution of respondents according to their levels of education is shown in the Table 4.2.

Table 4.2: Respondents' Distribution According to the Education

Education Level	**Frequency**	**Percentage**
Education of Staff Respondents		
Certificate	**22**	**44**
Diploma	**8**	**16**
Bachelor	**18**	**36**
Masters	**2**	**4**
Sub-Total	**50**	**100**
Education of Recipients Respondents		
Primary Education	12	30
Ordinary Secondary Education	6	15
Advanced Secondary Education	2	5
Collage/University Education Level	20	50
Sub-Total	**40**	**100**
Total	**90**	**100**

Source: Field Data Survey, 2015

The number of respondents taken from each section varied as shown in the table 4.2 depending on several factors such as; total number of workers in each section/department, availability of respondents and willingness of respondents to volunteer in providing information required by the study. The inclusion of respondents from various sections shows that the information collected is representative because the opinions have been collected from each section of the Regional Referral Hospital.

The study findings revealed more than 18(36%) of the service providers consulted by this study were holders of at least a bachelor degree in their respective specialization. The respondents were drawn from several departments/sections, which include surgery section, OPD, physiotherapy section, maternal care, laboratory section, optometry, medical services, dentistry and health section.

For the case of health service recipients, the study found that 37 that is over (92%) of the service recipients were coming from within Dodoma municipality and the rest were from either outside the municipality or outside Dodoma region. The study also found that most respondents 20(50%) had attained at least a university education and the rest had education levels lower than university education. This situation can probably be explained by the number of university students whose population in Dodoma keeps on increasing as a result of increase and/or expansion of the higher learning institutions over the past decade (CDA, 2010). The results shown in the Table 4.3 indicates that most respondents had education levels which could support them making thorough analysis of the health services provided by the Dodoma Regional Referral Hospital as a public hospital.

4.1.3 Age Distribution of the Respondents

Most of the service recipients (patients) who were involved in the provision of data for this study were the people whose age groups ranged from 26 years to 59 years old. The Table 4.3 shows the distribution of respondents according to their age groups and their areas of domicile.

Table4.3: Distribution of Respondents According to Age Groups

Age Group	Frequency	Percentage
19 - 25	**9**	**22.5**
26 - 59	**31**	**77.5**
60+	**0**	**0**
Total	**40**	**100**

Source: Field Data Survey, 2015

Findings above depict that; about 23% of the total respondent's their age group range between 12-25 years while about 76% of them their age group range between 26-59 years and no respondents employed in this study above 60 years. The findings portray that; the majority of respondents (76%) were of the age group between 26-59 years.

The world health organization WHO, (2002) ascertains that the brain of people with the age ranging from 20 to 55 years of age have good mental ability to analyze things in various contexts. However, this ability may be influenced by other factors like education levels, and the degree of insanity (Yilmaz, 2011 and Wertsch, 1997). Based on this fact therefore, it can be deduced that, respondents who were involved in provision of data for this study had relevant qualification of being able to internalize the health service provision practices at Dodoma Regional Referral hospital and give their opinions respectively.

4.1.4 Respondents' Marital Status

This study also assessed marital status of respondents how married couples and those who are not married perceive the services offered by Dodoma Regional Referral Hospital in Dodoma.

The respondents consulted by this study were such that; 27 over 50 percent of respondents were married while 11 over 27 percent were single and the rest were either divorced or widows/widowers. The Table 4.4 shows respondents distribution according to their marital statuses.

Table4.4: Distribution of Respondents According to Marital Status

Respondents	**Frequency**	**percentage**
Married	23	57.5
Widow/Widower	3	7.5
Separated	3	7.5
Single	11	27.5
Total	**40**	**100**

Source: Field Data Survey, 2015

Findings from table 4.4 illustrate that; approximate 56% of all of the respondents were married; approximate 8% of them were widow/widower and separated respectively. The last group approximate 28% were single. The mixture of respondents of different marital statuses implies that this study collected information from people with various life experiences and varied needs of health services. The national healthcare policy give directives on how to provide health service to different individuals according to their social groupings such as age, gender and marital statuses in a way that each group is served according to their special needs (URT, 2003). The assessment of respondents' marital status was meant to understand their diversity so that the perceptions and opinions about how health service is provided in this hospital may be captured according to their diversity in marital statuses.

4.2 Health Service Provision Practices in Dodoma Regional Referral Hospital

In this variable this study focused on assessing issues like; the manner patients are handled in both normal and fast-track options, willingness of service providers to attend patients in fast track and non-fast track category, Reliability of health service provided in both categories (fast track and non-fast track category) and Perceptions of service recipients on categorization of health service.

4.2.1 The Manner Patients are Handled in Both Normal and Fast-Track Options

The study revealed that both fast track and non-fast tract (normal) health services are provided in this regional referral hospital. In addition, the study also revealed that patients in the non-fast track option were handled in a different way from their fellow patients receiving health services through fast track option. The major difference in handling of patients from these service options were noted on the time taken for a patient to see and be attended by the service provider (nurse/doctor). The differences in their treatment are primarily based on the costs incurred in getting the service. The study found service costs varies among patients in the fast track and no-fast track service, but also within those categories, the cost varies from one patient to another depending on various factors such as type of a disease that a patient is suffering and the social grouping from which a patient belong like pregnant women, children and elderly people are treated differently especially in the non-fast tract service option. Table 4.5 illustrate findings concerning charges incurred by fast track patients

Table 4.5: Summarized Charges Incurred by Fast Track Patients

Descriptive Statistics					
Statistical Parameter	**N**	**Amount of Charges in TZS**			
		Minimum	**Maximum**	**Mean**	**Std. Deviation**
The amount charged to fast track patients	12	20,000	270,000	92500.00	107439.201
Valid N (list wise)	12				

Source: Field Data Survey, 2015

When respondents were asked to explain the amount of money they paid to be served in the fast track option, the result showed that the amount in which individual patient incurred ranged from TZS 20,000 to TZS 270,000 as table 4.5 shows. Consequently, these huge differences amount of money is not affordable by a most simple Tanzanian person and violates the Tanzania health policy that instructs health services to be free for adults over 60 years, children under five years, pregnant women and the disabled. This merely signifies that there in this referral Hospital once looking at its mechanism there is a huge system failure and deplorable situation on service giving and obvious corruption.

Therefore; the variation of amount of money paid by fast track service is due to the kind of disease case handled. The general costs for accessing fast track service seem to be relatively higher and difficult for many people to afford.

4.2.2 Respondents' Awareness about the Existence of Fast Track Services

Respondents were asked to state whether they were aware about the existence of fast track services and significant number of respondents respond on this question as shown in table 4.6.

Table 4.6: Respondents' Awareness about the Existence of Fast Track Services

Respondents	Frequency	percentage
Aware	37	**92.5**
Not aware	3	**7.5**
Total	**40**	**100**

Source: Field Data Survey, 2015

Significant number of respondents 37(93%) of them were aware about it but amazingly when the same people were asked to state if they have ever used this service, only 12(32%) were able to access this service. Owing to this findings many people despite their awareness on the existence of fast track services, most of them do not use such services and this is due to costs for accessing fast track service as seemed to be relatively higher and difficult for many people to afford.

4.2.3 Respondents' Experience with the Fast Track Services

Table 4.7 illustrates findings concerning respondents experience with the fast track services as collected by using questionnaire.

Table4.7: Respondents' Experience with the Fast Track Services

Respondents	Frequency	Percentage
Ever used	12	**32.2**
Never used	25	**67.8**
Total	**37**	**100.0**

Source: Field Data Survey, 2015

When respondents especially those who have never used fast track services were asked to explain their abscondment from using such services most of their responses were focusing on financial constraints that most people were facing that it made it impossible for them to access fast track services given higher costs associated with such services.

A good example may be drawn from one among the respondents who were asked to explain why she could not go for fast track service, of the respondents gave the following explanation;

> *"Fast track is a good service because one is able to see a doctor at any time he/she wishes, but how dare can a person like me affords such a service while even a day meal for my family is not assured".*

The statement like this implies that fast track services in the health sector is discriminatory since most people can hardly afford the minimum costs of such service which was shown in the data obtained when people who experienced such service were sharing their cost experiences.

4.2.4 Willingness of Service Providers to Attend Patients in Fast Track and Non-Fast Track Category

Willingness of service providers to attend patients through non fast track service was assessed by asking service provider to state which among the two patients category they would prefer most to serve among those patients who get health services through fast track and those who used non fast track services as the table 4.8 shows.

Table 4.8: Preference of Service Providers to Attend Either Fast Track or Non Fast Track Patients

Respondents	Frequency	Percentage%
Fast track	14	28
Non fast track	2	4
Both options	34	68
Total	**50**	**100**

Source: Field Data Survey, 2015

Table 4.8 reveals that; about 28% of the total respondents urged that they prefer to attend patients in fast track while about 4% of the total respondents urged that they

prefer to attend patients at non fast track and about 68% of them urged that they prefer to attend patients in both fast track and non fast track. The results showed that most of service providers showed willingness to serve patients in both categories. An interesting thing may however be noted that medical doctors especially the specialists showed their preference more on the fast track than non fast track options.

Most service providers 34(68%) are willing to serve the patients in both fast track and non fast track services. Further observation reveals that most of the specialist medical doctors prefer to serve patients who seek for fast track health services than those who come for normal services that are non fast track health service. This may be explain by the fact that, when specialist medical doctors are consulted by patients who seek service through fast track option, some percentage of the charges paid by the patient is given to the doctor attended that patient.

4.2.5 Major Difference Between Fast Track and Non Fast Track

As analyzed herein, it can be observed from the results displayed, table 4.9 summarizes the results obtained when service providers were responding to this question.

Table 4.9: Major Difference Between Fast Track and Non Fast Track

Responses	Frequency	Percentage
Quality of Service	10	20
Costs Only	9	18
Costs and Quality of Services	31	62
Total	**50**	**100**

Source: Field Data Survey, 2015

The results displayed by responses in the table 4.9 suggest that there is a difference in the quality of service provided between fast track and non fast track service in this hospital. The researcher asked service providers to confirm the difference in the service provided between fast track and non fast track services.

When they were asked to state if there is any difference between the two service options, the responses given by service providers showed that 50(100%) of health service providers confirmed that there is a difference in services provided between the two service options. When they were asked to describe more about the difference between the two service options, the results showed that the difference lies on both the cost and quality of the services.

4.2.6 Reliability of Health Service Provided in Both Categories

The reliability of service was assessed using opinions from service recipients (patients) especially on how accessible the service they experienced and their opinions about the quality of service they received. This question was directed to only those patients who had experience from both fast track and non fast track health services. This observation was commended by service providers as it has been shown in the table 4.10.

Table 4.10: Reliability of Health Service Provided in Both Categories

Responses	Frequency	Percentage
High Quality in Fast track	34	85
Low Quality in Non fast track	6	15
Total	**40**	**100**

Source: Field Data Survey, 2015

When they were asked to rank the quality of service in terms of how relevant the treatment was with respect to their sickness cases; 85 percent recommended fast track to be of relatively high quality compared to the services provided through non fast track while 15% of them commence that there are low quality of services in non fast track.

4.2.7 Opinions of Health Service Recipients about Fast Track Service

Respondents asked to show their services preferences between fast track and non fast track.

The responses concerning this question summarized in table 4.11.

Table 4.11: Opinions of Health Service Recipients about Types of Services

Service Type	Frequency	Percentage
Fast track	35	87.9
Non fast track	5	12.5
Total	**40**	**100.0**

Source: Field Data Survey, 2015

Table 4.11 reveals that, around 88% of the entire respondent's opted fast track health services while around 12% opted non fast track health services in the study area. Most people regardless of whether they were able to access fast track or not, commends the fast track service in a positive way.

4.2.8 Perceptions of Recipients on Categorization of Health Service

The patients who were sampled by this study were asked to explain how they do perceive fast track service; they gave their opinions that showed in the table 4.12

Table 4.12: Perceptions of Recipients on Categorization of Health Service

Responses	Frequency	Percentage
It is Good and Should be Maintained	11	27
It is not Good and Should be Discouraged	6	15
It may Proceed but with some Adjustments	23	58
Total	**40**	**100**

Source: Field Data Survey, 2015

Findings from table 4.12 depict that; around 27% of all of the respondents urged that; fast track is good and should be maintained while around 15% were of the views that fast track is not good and should be discouraged and around 58% portrayed that fast track may proceed but with some adjustments.

Basing on these findings the majority of respondents want to see it continue existing in the health sector but with some adjustment.

The record of such adjustment proposed by respondents revealed that the cost especially associated with the "consultation fee" should be reduced so that more people may be able to access that service.

4.3 Perceptions of Service Providers on Non-Salary Incentives

In a course of trying to capture the perceptions of service providers about non-salary incentives, the researcher asked service providers to tell if they are satisfied with the non salary incentives that they are provided. The responses showed that 50(100%) of all the service providers were not satisfied on the way that they are treated especially in terms of non-salary incentives.

4.3.1 Incentives are Sufficient

Respondents also asked to state if the incentives provided to them are sufficient or not. Table 4.13 illustrates the findings.

Table 4.13: Incentives are Sufficient

Responses	Frequency	Percentage
Yes	2	4
No	48	96
Total	**50**	**100**

Source: Field Data Survey, 2015

Basing on the findings above; 96% of the total respondents depict that; the incentive given to them are insufficient while only 4% of them point out that the incentive given to them are sufficient. This reveals that most of respondents are not satisfied with incentives provided to them.

4.3.2 Incentive Service Providers Would Prefer

When individual workers were approached to explain apart from the Salary, what kind of incentive they would prefer, their responses showed variety of incentives and the most commonly mentioned incentives are presented in table 4.14.

Table 4.14: Incentive Service Providers Would Prefer

Responses	Frequency	Percentage
Housing allowance	20	40
Risky allowance	15	30
Transport allowance	10	20
Extra-duty allowance	2	4
Exemption on some taxes and levies	3	6
Total	**50**	**100.0**

Source: Field Data Survey, 2015

Further assessment discovered service providers with higher ranks like medical specialists preferred most the allowances associated with exemption from taxes associated with importation of goods from other countries while other service providers in the lower rank demanded incentives like housing and transportation allowances. This may probably be explained by the fact that medical specialists and other high ranking officials do not struggle much on issues of housing and transport issues which is opposite from health providers in the lower ranks. Therefore this situation of not satisfied by the current non salary incentives offered by the government through Dodoma Regional Referral Hospital may influence health service providers to find alternative sources of raising their income and these may include corruption practice.

4.4 Managerial Capacity in Fighting against Malpractices in Service Provision

The information about managerial capacity of the hospital in fighting against malpractices in the health service provision were collected by asking service providers

if they have heard any employee being convicted of not performing well in his/her job responsibilities. The researcher asked respondents to speak of other fellow employees because it is well understood that it is not possible for a person to disclose his/her experience in being punished as a result of poor service delivery.

The responses obtained from respondents about this question revealed that none of the employees were able to explain at least one vivid example of the fellow employee that has been disciplined due to failure in offering desirable health service to clients (patients).

Failure of workers to cite any example of a employee who has been disciplined due to malpractices suggests that there is weak internal managerial mechanisms to deal with workers whose performance does not measure up to clients expectations and guidelines of health service provision. On the other hand, this information would mean that every worker at that hospital is doing his/her job assignments as expected by the management and meeting the expectations of service recipients.

4.4.1 The Condition of Non Fast Track in the Study Area

Respondents asked to show the condition of non fast track in the study area and table 4.15 summarizes the findings concerning this question.

Table 4.15: Incentives are Sufficient

Responses	Frequency	Percentage
Very Poor	34	85
Very Good	6	15
Total	**40**	**100**

Source: Field Data Survey, 2015

In trying to verify the truth about this condition, the researcher asked service recipients to explain how they do perceive the quality of services provided by workers in the

hospital especially through the non-fast track service. Most of them 34 respondents out of 40 comments that service provided is very poor equal to 85% of respondents and only 15% recommended that this services is very good. When further asked on the basis for their answer they claimed that it takes time to see a doctor, no medicines and other health equipments and others said health service provider's probes asking for bribes.

4.4.2 The Extent of Corruption in this Hospital

Respondents required to explain the extent of corruption in the study area as summarized in table 4.16.

Table 4.16: The Extent of Corruption in this Hospital

Responses	Frequency	Percentage
Very High	25	62.5
Moderate	10	25
Low	3	7.5
No Such a Problem	2	5.0
Total	**40**	**100**

Source: Field Data Survey, 2015

Findings from table 4.16 depict that; approximate 63% of all of the respondents comment that; the level of corruption in the study area is high, 25% of them commence that the level of corruption is moderate while approximate 8% of them point out that the level of corruption in the study area is low and 5% of them urged that no such a problem in the study area.

4.5 Summary

This chapter has focused on the analysis of data and presentation of the research findings. It commences with Social-Demographic Profile of the Study Population following to the analysis of objectives of the study. The following chapter describes the summary, conclusion and recommendations for this study as well as suggested area for further study.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter reiterates the findings obtained from the fieldwork undertaken on the provision of health services in government hospitals conducted at Dodoma Regional Referral Hospital as a study case and principally paying attention on assessing various aspects associated with the general provision of health services and the way clients of such services. Then, it gives recommendations on what should be done to eradicate malpractice of health service providers that will result to improved health service provision.

5.1 Summary of the Findings

The findings obtained during the fieldwork, as presented and discussed in the previous chapter, have uncovered that health provision practices is done through two service provision options namely fast track and non fast track. The study also unveils that the former option is delivered in relatively high quality than the latter. Besides, this analysis further divulges that some service providers prefer fast track more than non fast track service because it has been found that service providers are given some incentives from the money that patients pay for the fast track service. The perceptions of service providers on non salary incentives showed that all workers are not satisfied with the currently provided incentives. In addition the study revealed that managerial capacity for the administrative organ has not been able to discover and hence execute disciplinary measures to any worker for a long period of time which indicates low managerial capacity in handling service provision malpractices.

The provision of health service in Dodoma Regional Referral Hospital has been convicted by many people and being provided in manner that does not measure up to people's expectations. These problems have seldom been heard from the health facilities owned by the private sector. The major reasons accounting for those claims does not exclude inadequate managerial capacity of those health facilities and individual workers' malpractices that may be cause by corruption and dissatisfaction of workers on the incentives they are given by the government.

This study revealed that, health services in this hospital is mainly provided through two service options which are fast track and non fast track. The assessment of this study on these two service options revealed that the cost and quality associated in these options varies. While the costs in fast track are relatively higher than those in non fast track, the quality of service also follows the same flow in that, quality of service in non fast track are relatively poorer compared to those provided through fast track options.

The study further revealed many malpractices in service provision have been experienced especially by the patients who have been getting health service through non fast track service option. The reason for the differential treatment of patients in these two option have been found to be caused by the additional costs that patients in the fast track option have been paying which is partly given by the medical doctors consulted by such patients.

The assessment of managerial capacity of the hospital administration revealed that disciplinary measures in the hospital are either seldomly executed or not executed at all.

This was evidenced by responses given by service recipients when they had no idea of whether there was a person in the hospital in whom disciplinary measures were executed.

5.2 General Conclusion

The provision of health service in most of government health facilities has been convicted by many people and provided in manner that does not measure up to people' expectations or meet guidelines for health service provision. These problems have seldom been heard from the health facilities owned by the private sector. The major reasons accounting for those claims does not exclude inadequate managerial capacity of those health facilities and individual workers' malpractices that may be cause by corruption and dissatisfaction of workers on the incentives they are given by the government.

In general, this study argues that the explored subject as researcher contribution to his community challenges if seriously considered may be helpful for all stakeholders and still viable in resolving many problems of provision of health service in most of government hospitals. Furthermore, slotting in the suggested measures and ways to enhance its viability as given in this study will improve the resolution process and consequently lead to a positive outcome.

5.3 Recommendations

Health service is one among the basic needs that is entitled for all humankind. Differentiated health service provision through fast and non fast track options in the same health facility like in Dodoma Regional Referral Hospital, has shown to worsen the situation of service provision by attracting some service providers to one option and

makes them unavailable to the other. Because of these discrepancies this study recommends the following:

i. There should be differentiated health service staff in the fast track and non fast track service option. This will help to reduce the problem of service providers lose interest when serving clients through non fast track option, as they will be comparing the benefits they get when serving patients in the fast track service option.

ii. Service providers who serve patients in the non fast track options should be given extra-incentives so that they may get additional allowances as those workers who are serving patients through the fast track service option.

iii. The government through the ministry of health should make some arrangements to provide more subsidies to the health facilities offering fast track service so that the costs associated with provision of fast track service may be reduced to give an opportunity for many people to access such service. This recommendation is made following the observation recorded from some respondents who claimed that the costs that fast track service have been charged higher than the financial capacity of many people to access such service.

iv. The administrative organ of health facilities should make sure that they device a mechanism to collect opinions from their clients so that they may be able to understand the level of malpractices done by workers and take the appropriate measures in such cases. This will help to discipline the workers who have been convicted by clients of being offering low quality service below the expectation of the recipients of health services or claimed to demand corruption so that to provide services.

5.4 Suggested Area for Further Study

Having analyzed different variables associated with this study (which is the general practices of health service provision, managerial capacity in fighting against corruption and perceptions of service providers on non-salary incentives), the description was offered to explain the implications of each variable and how it links with the empirical practices taking place in the Dodoma regional referral hospital. It is also worthy noticing that, this study did not exhaust everything as far as "heath service provision practices in Dodoma regional referral hospital" is concerned. There are some areas that this study did not cover because they seemed to be out of scope due to a number of limitations including financial and time constraints. Such areas that call for further studies include the following:

i. Accessibility of the basic health services to the people from different economic background as it has been ascribed in the national health policy. This is an area that requires further studies because although the observation made by this study revealed that non-fast track option costs relatively cheaper than fast-track (which may imply that this options serves many people), but the degree at which that service is cheap, does not necessarily guarantee accessibility of health service to all people especially those from extremely poor economic backgrounds.

ii. Functional relations between health providers and managerial authorities. This venture will help to investigate more about how the claims and dissatisfactions from health service providers are seconded to higher authorities for actions and on the other hand how does higher authorities get informed about behaviour pattern of service providers and execute some disciplinary measures to correct

some noted misdemeanour. This areas is proposed because when this study was done, it was observed that many service providers had some needs that were burning in their souls (it was noted as they were responding to the question which asked them to tell if they are satisfied with non-salary incentives) which seemed to have not landed on the attention of managerial authorities for action. On the other hand, this study was shocked to see many grievances from service recipients that seemed unfamiliar to the hospital's managerial authorities. This situation suggested that there is a missing link between how the information about dissatisfaction of health recipients and health providers reaches to the managerial authorities for action and inversely, how does managerial authorities get informed about the performance of their sub-ordinates (health service providers). This study suggested in this paragraph will help to merge this gap.

iii. Non-financial and time factors that differentiate the quality of service between fast track and non-fast track option. When both service providers and service recipients were asked to explain the difference between the two service options, they mentioned nothing but only two factors namely time and amount of money to be the factors that differentiate the two options. This area is important and worthy for further investigation because it was noted that, medical specialists seemed to be more willing to serve people in the fast track than non fast track to financial gains. This observation came into researcher's understanding that probably there may be some difference in the quality of services provided by especially medical specialist between the patients in these two options because they financial gains would definitely influence their moody of service and hence service provision.

This is very important because if this situation exists and care is not taken, public hospitals may end up providing discriminatory quality of service by neglecting the poor due to their inability to pay for fast track service.

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APPENDECES

Appendix 1: Questionnaire for the Service Recipient

Dear Respondents,

I, am **Paul Masanja,** writing an investigation on Assessment on Health provision service in Tanzania: A case of Dodoma Regional Referral Hospital. An intention of this questionnaire is to learn the current situation of health provision services in Tanzania government hospitals: a case of Dodoma regional referral hospital. Please do not write your name on this form and be informed that the replies remain anonymous. Please answer the questions with utmost honesty and best of your knowledge, by putting (√) where appropriate and almost all questions have multiple answers. Thank you for your time.

SECTION A: PROFILE OF RESPONDENTS

1. Sex
   i. Male
   ii. Female
2. Education level

3. Education level
   i. informal education
   ii. primary education
   iii. ordinary secondary education
   iv. advanced secondary education
   v. collage/university .
4. Occupation
   i. peasant/farmer
   ii. businessperson
   iii. employee

5. Marital status

i. Married

ii. Widow/Widower

iii. Separated

iv. Single

SECTION B: EXPERIENCE WITH HEALTH SERVICE PROVISION

6. Do you know fast-track health service (1) yes (2) no

7. Have you ever used fast track health service in this hospital (1) yes (2) no

8. If yes, how can you compare the quality of service between fast track and non fast track services?

i. fast track is better than non fast track

ii. non fast track is better than fast track

iii. no any significant difference between the two

9. In your opinion, how would you recommend about the fast track health service

i. It is good and should proceed

ii. It is not good and should be stopped

iii. It should be modified

10. What do you suggest as a modification to be done in the current fast track service ……

SECTION C: PERCEPTIONS OF SERVICE PROVIDERS ON NON-SALARY INCENTIVES

11. How can you explain the services provided by this hospital?

i. very good

ii. good

iii. poor

iv. very poor

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12. How can you rate the extent of corruption among service providers in this hospital

i. Very High

ii. Low

iii. Nil

13. What do you think is the major influencing factor for the situation you have answered above……

.....

Appendix II: Questionnaire Guide for the Health Service Providers

Dear Respondents,

I, am **Paul Masanja,** writing an investigation on Assessment on Health provision service in Tanzania: A case of Dodoma Regional Referral Hospital. An intention of this questionnaire is to learn the current situation of health provision services in Tanzania government hospitals: a case of Dodoma regional referral hospital. Please do not write your name on this form and be informed that the replies remain anonymous. Please answer the questions with utmost honesty and best of your knowledge, by putting (√) where appropriate and almost all questions have multiple answers. Thank you for your time.

SECTION A: PROFILE OF RESPONDENTS

1. Department/occupational section …….
2. Age ……
3. Education level …….
4. How long have you been working with the health sector ……

SECTION B: EXPERIENCE WITH HEALTH SERVICE PROVISION

5. How can you generally explain the health services provided between those people using fast track and non fast track services
   i. They are the Same
   ii. They are not the Same
6. Basing on your answer in the question above, which category of service recipient receives relatively better services
   i. Fast Track
   ii. Non Fast Track
   iii. Both of Them

7. In your own opinion, which among these two groups of service recipient you would prefer to attend
   i. Fast track
   ii. Non fast trace
   iii. Both of them
8. Can you please explain the reason for your answer above
9. Have you ever received any complaints from your clients (health service recipient) on the service they get from your hospital
   i. Yes
   ii. No
10. If your answer above is yes, which among the two categories of your clients gave the claims the most
   i. Fast track
   ii. Non fast track
   iii. Both of them

SECTION C: PERCEPTIONS OF SERVICE PROVIDERS ON NON-SALARY INCENTIVES

11. A part from the salary, which other incentive do you receive from your employer?

12. In your opinion, do you think that such incentives are sufficient for you?
   i. Yes
   ii. No
13. If no, what and how would you like to be provided for?

……

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13. How can you generally explain about the extent of corruption in this hospital?
    i. Very high
    ii. Moderate
    iii. Low
    iv. There is no such a problem

15. Are there any measures taken by the hospital management in preventing or combating corruption cases
    i. Yes
    ii. No

16. What do you think is the major influencing factor for the situation you have answered above

……..

17. Can you explain the effects of those measures by using the following table as your guide?

.....

……

Appendix III: Schedule for the Study:

The Study Started in January 2014 and Ended up in October, 2015

ACTIVITY	2014							2015			
	J	F	M	J, M	J, J	A, S, O	N, D	J, F	M, A	M, J	J,A
Generating idea, conceptualization, and approval of the topic.	■	■									
Preparation and presentation of research concept note.		■	■								
Writing, submission and review of research proposal.				■	■						
Re-writing and presentation of research Proposal to research committee for approval.						■					
Field data collection.							■				
Data presentation and analysis.								■			
Dissertation writing.									■		
Submission of first version of dissertation to supervisor for review & comments.										■	
Re-writing the dissertation as per supervisor's comments.											■
Submission of the final version of dissertation for marking.											■

Source: Field Data Survey, 2015

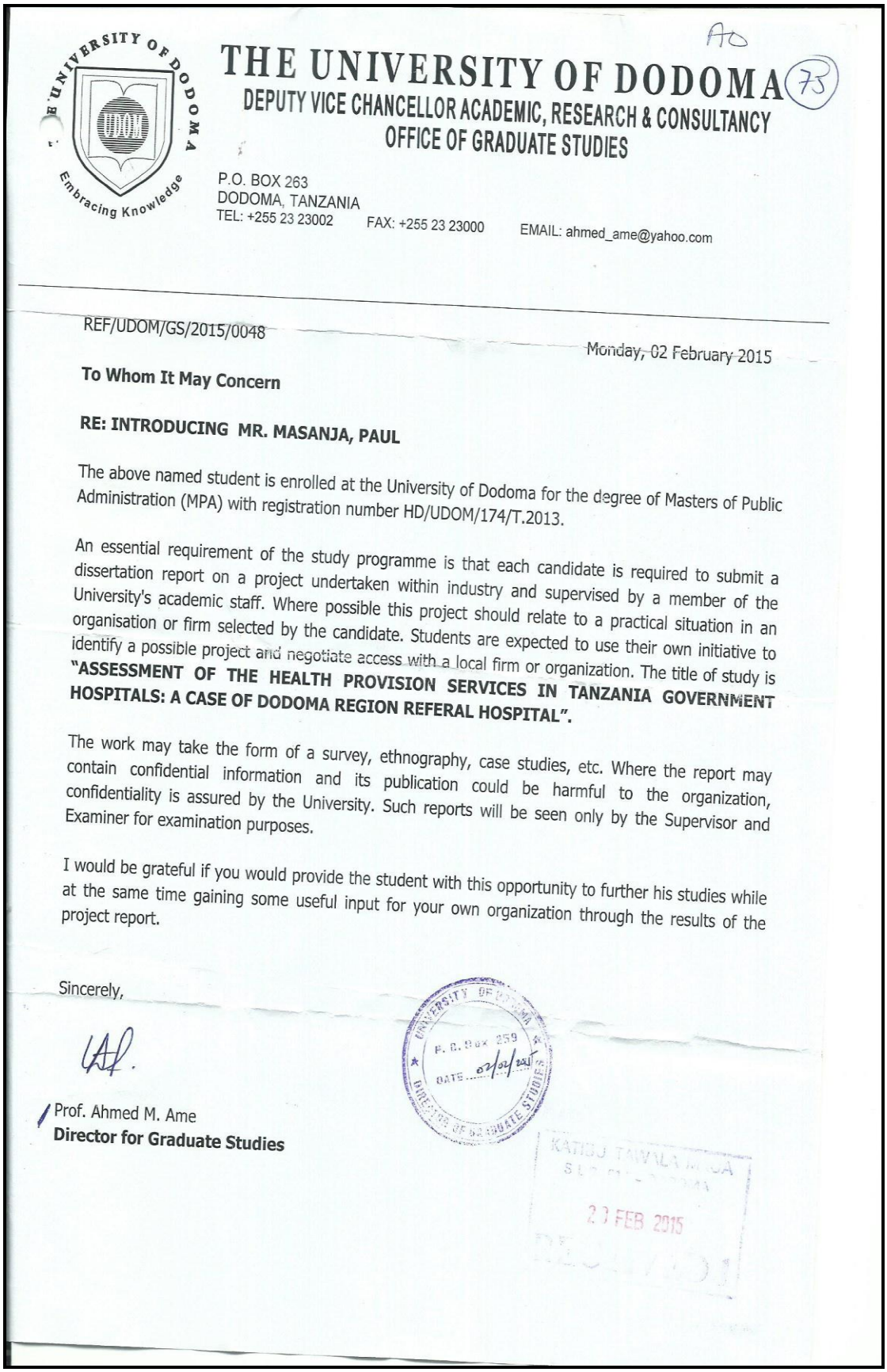
Appendix IV: Research Budget and Source of Fund

The study was privately sponsored at the total cost of two million seven hundred thousand and ninety shillings (2,790,000/= Tshs.). See the budget breakdown in table below:

Activity	**Cost in Tshs.**
Development of research proposal	70,000/=
Field work	500,000/=
Accommodations	480,000/=
Meals	600,000/=
Transport	640,000/=
Stationeries & secretarial work	500,000/=
Grand Total	**2,790,000/=**

Source: Field Data Survey, 2015

Appendix V: Introduction Letter from UDOM



THE UNIVERSITY OF DODOMA
DEPUTY VICE CHANCELLOR ACADEMIC, RESEARCH & CONSULTANCY
OFFICE OF GRADUATE STUDIES

P.O. BOX 263
DODOMA, TANZANIA
TEL: +255 23 23002 FAX: +255 23 23000 EMAIL: ahmed_ame@yahoo.com

REF/UDOM/GS/2015/0048

Monday, 02 February 2015

To Whom It May Concern

RE: INTRODUCING MR. MASANJA, PAUL

The above named student is enrolled at the University of Dodoma for the degree of Masters of Public Administration (MPA) with registration number HD/UDOM/174/T.2013.

An essential requirement of the study programme is that each candidate is required to submit a dissertation report on a project undertaken within industry and supervised by a member of the University's academic staff. Where possible this project should relate to a practical situation in an organisation or firm selected by the candidate. Students are expected to use their own initiative to identify a possible project and negotiate access with a local firm or organization. The title of study is **"ASSESSMENT OF THE HEALTH PROVISION SERVICES IN TANZANIA GOVERNMENT HOSPITALS: A CASE OF DODOMA REGION REFERAL HOSPITAL".**

The work may take the form of a survey, ethnography, case studies, etc. Where the report may contain confidential information and its publication could be harmful to the organization, confidentiality is assured by the University. Such reports will be seen only by the Supervisor and Examiner for examination purposes.

I would be grateful if you would provide the student with this opportunity to further his studies while at the same time gaining some useful input for your own organization through the results of the project report.

Sincerely,

Prof. Ahmed M. Ame
Director for Graduate Studies

Appendix VI: Introduction Letter from RAS Dodoma

THE UNITED REPUBLIC OF TANZANIA
PRIME MINISTER'S OFFICE
REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

Dodoma Region
Address REGCOM
Tel. No: 2324343/2324384
E-Mail No *Ras.dodoma@pmoralg.go.tz*
Fax No: 255 026 2320046

Regional Commissioner's Office
S.L.P 914
Dodoma.

Ref. No. DA.122/467/01/B/76

23 February, 2015

Regional Medical Officer,
Dodoma Referral Hospital
P.O.BOX 904,
DODOMA.

RE: RESEARCH PERMIT

This is to introduce to you Mr.Masanja Paul who is a bonafide Student of the University of Dodoma and who is at the moment conducting research in Dodoma Region.

The title of the research is " **An Assessment of the Health Provision Services in Tanzania Government Hospitals: A case of Dodoma Region Referral Hospital** ". Please accord him with all necessary assistance to achieve her research objectives.

Thank you for your cooperation

E. Y. Mwasote
For: REGIONAL ADMINISTRATIVE SECRETARY
DODOMA.

Copy to: - Director for Graduate Studies,
P.O.BOX 263,
Dodoma.

: Mr. Masanja Paul
University of Dodoma.