AN INVESTIGATION OF CHALLENGES FACING PROVISION OF HEALTH SERVICE AT NGASAMO VILLAGE IN BUSEGA DISTRICT

By
MabeyoLeah

A Dissertation Report Submitted to Mzumbe University Dar es salaam Business School in a Partial Fulfillment of the Requirements for the Award of Master of Public Administration (MPA) 2013
CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **An investigation of challenges facing provision of health service in Ngasamo village in Busega District** submitted in partial fulfillment of the requirements for the award of the degree of Master of Public Administration of Mzumbe University.

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I, Mabeyo, Leah, declare that, this research report is my original work and that it has not been presented to any other University for a similar or any degree award.

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ACKNOWLEDGEMENT

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## LIST OF ABBREVIATION

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>NGO’s</td>
<td>Non-Governmental organisation</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>WHO</td>
<td>World health organisation</td>
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<tr>
<td>HR</td>
<td>Human Resource</td>
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<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
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<tr>
<td>TNA</td>
<td>Training Needs Assessment</td>
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<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<tr>
<td>HIV</td>
<td>Human immune Virus</td>
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<td>AIDS</td>
<td>Acquired immune Deficiency syndrome</td>
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ABSTRACT

Provision of health service in rural areas, is the process of increasing standard of life, this is the basic health care service provided by the health service delivery system, it requires a health delivery system with adequate and properly trained staffs who are accessible to patients and supplied with the necessary material resources, the interventions will vary from one district to another in order to accommodate local burden of diseases. The purpose of provision of health service in Ngasamo village is remove the gap between for those who living in rural area and urban.

The purpose of this study was to investigate the challenge hindering provision of health service at Ngasamo village in Busega district. The specific objectives of the study were, to assess the community perception towards health service provided at Ngasamo village, to identify challenges that hinder effective provision of health service in Ngasamo village, to identify the strategies to overcome the challenges hindering effective provision of health service in Ngasamo and to identify challenges hindering provision of health service at Ngasamo and to make suggest the strategies to overcome challenge hindering provision of health service programs on public hospitals.

Data collection methods comprised interview, focus group discussion, documentary analysis, internet search and observation. The study deployed two sampling techniques which are simple random sampling and purposive sampling. The data analysis to answer the research questions included the use of descriptive statistics. The results indicated that there were positive perception about challenges despite its cost, budget constraints and lack of implementation of PPP policy in village, as the major hindering challenges for the provision of effective health, and Study revealed that training budget should be added, health service policy should established and there should public private partnership (PPP).

Several recommendations have been made as employees should have positive perception towards health service provision, ministry should seriously invest in health, and government should add budget for provision of health service.
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CHAPTER ONE
INTRODUCTION AND BACKGROUND TO THE PROBLEM

1.0 Introduction
This chapter presents background to the problem, statement of the problem, general objective of the study, specific objectives, research questions, significance of the study, limitations of the study and de-limitations of the study.

1.1 Background to the problem
Public Health Act, 2009 was established by an Act of Parliament No. 1 of 2009 and subsequently amended under the Written Laws (Miscellaneous Amendment) Act No. 2 of 2011, with the major functions is clearly stipulated in the Act which established of provision, promotion, preservation maintenance of public health and to ensuring the provision of comprehensive, function and sustainable public health services to the public,(National Health Policy, 1990).

National Public Health is endeavoring with various local and international development partners such Non-governmental Organization, Civil Society and Central Ministries, as Regional Administration and Local Government, and Community Development, Gender and Children, which focuses on Creation, awareness on the realization on the national strategy for growth and reduction of poverty and other development policies aimed at promoting high quality livelihood among the Tanzanians.

The overlying mission is to facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive sustainable, improved health status, by providing direction towards improvement of the health status of all the people, by reducing disability, morbidity, mortality and improving nutritional status and raising life expectancy. Public health sector as among of public organizations has established policy in order to Reduce the burden of diseases, maternal and infant mortality and increase life expectancy through the provision of
adequate and equitable maternal and child health services, facilitate the promotion of environmental health and sanitation, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions. Ensure the availability of drugs, reagents medical supplies and infrastructures in order to ensure that health services are available and accessible by community, (urban and rural areas). To ensure availability of health providers who are competent and adequate number of health staff to manage health services with gender perspective at all levels. Capacity building of human resource must be done by management and health services provision will be addressed. Sensitize the community on common preventable health problems, and improve the capabilities at all levels of society to assess and analysis problems and design, (Bushy, 2000).

Appropriate action through genuine community involvement, Create awareness through family health promotion that the responsibility for one health rests in the individuals as an integral part of the family, community and nation, Promote and sustain public-private partnership in the delivery of health services, Promote traditional medicine and alternative healing system and regulate the practice, (Manongi,2006).

Since 2009 the Ministry of Health and Social Welfare uses a greater proportion of the health budget to target cost effective interventions such as immunization of children under 2 years of age, Reproductive and Child Health including Family Planning and control of Malaria, HIV/AIDS and TB and Leprosy. The majority of the poor and specifically the rural poor suffer from HIV/AIDS, TB and deprosy. The Ministry increases resource allocation to address these cost effective interventions, while at the same time join hands with other stakeholders, the communities and development partners to re-orient the services to be more responsive to the needs of the population, and specifically targeting the indigenous and the vulnerable groups, (WHO, 2003).
As the results environment in which National Health Policy is operating has changed tremendously. For instance there is an introduction of new quality and Strengthening District Health Services so that essential clinical and public health packages are provided to reduce the burden of disease, crude death rates, maternal and infant mortality rate, and increase life expectancy. Strengthening Referral System that are efficient and cost effective from the household to the National level, Adopt diversified complementary health care financing options, which are sustainable and involving Public-Private Partnership and other resources, to ensure availability of required logistics and support services which are affordable and accessible to every citizen. Enhance capacity at different levels by implementing comprehensive human resource development plan, which facilitate deployment and retention of well-trained and motivated staff at the appropriate health service level, Create public awareness at all levels through Advocacy and IEC on preventable public health problems and the need for active community involvement in taking care of their own health, Improve coalition and multisectoral collaboration, Ensure representation of stakeholders and communities in health service delivery, Increase public private partnership in health provision, Implement effective donor and other stakeholders co-ordination mechanism. In order to assurance promotion of good and quality health services both in rural and urban area.

1.2 Statement of the problem

Provision of health service in rural areas do not only to improve level of health service but also the development of human health psychological fit in any remote and urban area as an advantage among in the community, towards effective service, considering the technological changes. On the other hand, increased complexity of health service in rural has not been left behind in facilitating provision of health service programs to its people as one of the stepping stone toward service efficiency. Ministry of health as one of the public organization been established in 1988 and through its strategic plans of 1990 to 1997 and the reviewed of 1997 to 2012 it managed to training health personnel expansion of health service to meet the requirements at the different health care levels. Achievement in health sector have
led to arise in life expectancy from 35 years (1999) to 52 years (2004) and to reduction in infant mortality rate from 215 per 1000 in 2004 to 105 per 1000 in 2005. Despite the achievement reached by the ministry of health and social welfare in facilitating training and provision of health service to its services users, still the ministry of health and social welfare experienced complaints from beneficiaries and stake holders on its performance which is not satisfactory at all health service. Therefore, this is the reason that made me to develop an interest and to conduct research so as the investigate the performance and provision of health service in Ngasamo village public health centre

1.3 Objectives of the study
This study was guided by general objective and specific objectives.

1.3.1 General objective
The main purpose of this study was to examining the challenges facing provision of health services at Ngasamo village in Busega District.

1.3.2 Specific objectives.
  i. To assess the community perception towards health service provided at Ngasamo village

  ii. To identify challenges that hinder effective provision of health service at Ngasamo village.

  iii. To identify the strategies to overcome the challenges hindering effective provision of health service at Ngasamo.

1.4 Research questions
(i) What are the community’ perceptions towards provision of health service at Ngasamo village?
(ii) What are challenges hindering effective provision of health service at Ngasamo village?

(iii) What are strategies to overcome challenges hindering effective provision of health service at Ngasamo village?

1.5 Significance of the study

This study helped a researcher to meet one of the essential fulfillments for the University Requirement for the award of Master’s Degree of Public Administration (MPA).

It also contributed for increment of researchers’ skills, knowledge and attitude about the challenges that facing health services in rural area. Furthermore the findings of the study might provoke, to other stake holders to contribute more especially to create awareness to the beneficiaries about health service provided in the community.

Lastly this study is one of the sources which helped different scholars in academic realm to use as among of the references.

1.6 Scope of the study.

This research was designed to cover within Busega district in Tanzania. It was mainly limited to public hospitals where Ngasamo Health Centre was chosen as a case study.

1.7 Limitations of the study

The researcher faced the following limitations at the time of searching data; community members were not aware with health service provided to people; sometimes it was difficult for the researcher to get detail/information concerning the study due to the fact that most of the expected respondents have little information no information about the challenges that facing provision of health services at their areas.

Second, it was difficult to maintain gender balance due to the number of females expected to be not high compared to the number of males. Most of the females were
busy engaging incultivation activities. A part from that the researcher experienced personal values and attribute not all respondents were willing to provide enough information.

Lastly the researcher faced the problem of shortage of time and enough money to conduct the study.

1.8 **De-limitations of the study**

This study covered the challenges facing provision of health services in rural areas where by Busega district specific Ngasamo village used as the study area. Where by Professional health providers, local leaders and the villagers who live at that area were the sample for this study.
CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction
This chapter consists of theoretical literature review, empirical literature review, research gap and conceptual frame work.

2.2 Definition of terms
Health services are all services performed, provided, or arranged by the Services to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to, the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometric, medical food, and medical intelligence services, (Jung, 1997).

Health service should be able to meet both medical and psychosocial needs. However, most often care provided is costly and substandard, and imposes a heavy financial burden on poor households (World Health Organization, 2000).

Health services sometimes patients’ expectations are not met by professionals, Issues of concern to patients include care givers’ interaction with patients, accessibility of health services, availability of drugs and equipment, and cleanness (Haddad, 2006).

Health service is a service provided or secured by a public health body concerning the treatment, care and support of, and provision of advice and assistance to individuals in relation to health
and well-being, or similar services provided by independent health care service provider, (Gilson, 2007).

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, (WHO, 2000:100). Health is the level of functional or metabolic efficiency of a living being. In humans, it is the general condition of a person’s mind and body, usually meaning to be free from illness, injury or pain.

According to Matteru (2005), Public organization is a part of the state that deals with the production, delivery and allocation of goods and services by and for the government or its citizens, whether national, regional or local/municipal. Public Sector organizations are owned and controlled by the government (or local government). They aim to provide public services, often free at the point of delivery. Like primary education, police, social security, military, public roads, public transit, administering urban planning and healthcare for the poor, so public sector might provide services that non-payer cannot be excluded from services which benefit all of society rather than just the individual who uses the service that encourage equal opportunity.

2.3 Theoretical literature review
This theoretical review shows and identify challenges hindering provision of health service in villages/rural areas it is common lack of health facilities, lack of drugs and supplies and not on informal fees people were required pay. Shortage of skill provider particular located in remote rural areas and the distance, transport as among of problems due to transport lacking and in which communities are poor as evidenced by large number of people living below the poverty line, (Gwatkin, 2003).

2.3.1 National health policy
The Health Policy is a vital guide towards health development of any country. It is particularly,
Important in a country like ours where resources and technology are more limited than in other countries, which are relatively better off in both technology and resources.

Current, Tanzania national health policy is a revision of the 1990 Health Policy, which emphasized on the need for increasing community involvement in health development and improved access and equity in health and health services.

The Policy recognizes the challenges of consolidating the principles of the previous health policy in community involvement, improved health services provision, access and equity while addressing the different dimensions of reforms that are taking place in the Public Sector.

The national health policy is aimed at improving the health status of all people whenever they are, in urban and rural areas by reducing morbidity and mortality and raising life expectancy Good health i.e. physical mental and social well-being is a major resource and economic development.

However the overall objective of health policy in Tanzania is to improve the health wellbeing of all Tanzanians, with a focus on those at risk and to encourage the health system to be more responsive to the needs of the people. The specific objectives of the policy are, Reduce the burden of disease, maternal and infant mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, facilitate the promotion of environmental health and sanitation, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions.

The policy also aimed to ensure the availability of drugs, reagents and medical supplies and infrastructures, Ensure that the health services are available and accessible to all the people in the, country (urban and rural areas), Train and make available competent and adequate number of health staff to manage health services
with gender perspective at all levels. Capacity building of human resource at all levels in management and health services provision will be addressed, Sensitize the community on common preventable health problems, and improve the capabilities at all levels of society to assess and analyse problems and design appropriate action through genuine community involvement.

Promote awareness among Government employees and the community at large that, health problems can only be adequately solved through multispectral cooperation involving such sectors as Education, Agriculture, Water, Private Sector including, Non-Governmental Organization, Civil Society and Central Ministries, as Regional, Administration and Local Government, and Community Development, Gender and Children, Create awareness through family health promotion that the responsibility for one’s health rests in the individuals as an integral part of the family, community and promote and sustain public-private partnership in the delivery of health services, promote traditional medicine and alternative healing system and regulate the practice.

Even though health center service this is the second formal health unit of level one-health services. It is a primary health facility, which offers Outpatient and In-patient services, maternity care, laboratory, and dispensing and mortuary services.

A Health Centre shall cater for people and supervise all the dispensaries in the Division. Where the population is higher than 50,000, the level of services will be increased to accommodate a higher through put. The Ministry of Health shall standardize the staffing level, equipment, drugs, medical supplies, reagents, dental oral health and building plans. These standards will be revised as need arises. A Health Centre under the Local Government Authority through the Health, Centre Committee and Management Team, shall, Provide promote, preventive, curative and rehabilitative services, Act as the first referral center from dispensaries in its catchment’s area; keep health service data and records according to given guidelines, Provide feedback to other levels including dispensaries.
**Provision of Essential Drugs, Medical Supplies and Equipment and Reagents**

The provision of essential drugs, reagents, medical supplies, and equipment will be based on the National Drug and Supplies Policy Guidelines. The overall objective is to make available to all Tanzanians at all times the essential pharmaceutical products, medical supplies, and equipment which are of high quality, proven effectiveness, acceptable standard, and safety at a price that the individual and the community can afford. These are needed for health promotion, prevention, and treatment of illnesses.

This Policy is aimed at rationalizing the use of drugs and other commodities through better information, rational prescription, and compliance at all levels. It also aims at encouraging the growth of local industries in the manufacture of pharmaceuticals, medical supplies, and equipment for the purpose of meeting the local needs and creating the environment of local industries competing in the regional and international markets.

**Prevention and Control of Endemic, Epidemic and Pandemic Diseases**

Communicable diseases have remained a serious public health problem in Tanzania despite continued efforts to prevent and control them. The majority of the community has been informed about communicable diseases and epidemics. However, their behavior and environment in which the communities live have not changed significantly. The diseases in turn cause premature loss of life, disability, consume scarce national resources, affect economic productivity, and have the potential for undermining national development to the extent of eroding the gains realized. Special control programmes have been formulated against such diseases as Malaria, Acute Respiratory Infections, Diarrhea diseases, TB and Leprosy, HIV/AIDS/STI, and childhood immunizable diseases. The Health Policy is to integrate these programmes gradually within general health services so as to minimize the costs for utilizing the available resources and maximizing the benefits derived. Contain the spread of HIV/AIDS. Prevent the spread of other
communicable diseases in the communities, Achieve early detection of cases to control their spread within the Communities, Provide adequate treatment where applicable to all cases diagnosed, Promote environmental measures and behavioural changes to reduce transmission, Educate the people on prevention, detection and simple treatment of common, Diseases, Prevent nosocomial Infections.

The Ministry of Health emphasizes that prevention and control of communicable diseases will be within the scope of the National Package of Essential Health Interventions. Existing guidelines will be reviewed and updated from time to time to accommodate changes and improve environmental sanitation.

**Malaria**
The people of Tanzania suffer most from acute febrile illness caused by malaria. The groups most vulnerable to malaria are young children and pregnant women. Malaria is also the leading cause of death of all age groups for hospitalized patients. It is the leading cause of admissions and death in children under five years and above. The Government is committed to reduce the burden of disease due to Malaria. To address the problem, the Ministry of Health will apply four strategic approaches: Improved malaria case management, Use of Insecticide Treated mosquito Nets (ITNs), Control of malaria in pregnancy, and Malaria epidemics prevention and control.

All these strategies will be complemented by IEC on control and prevention of Malaria.

**HIV/AIDS**
The National response to the HIV/AIDS epidemic consists of developing strategies to prevent, control and mitigate the impact of the epidemic, in the presence of the epidemic, the Health Sector will continue to lead the national response on technical issues related to the following:

Prevention and control of HIV transmission strategies, which include: Sexually Transmitted Infections (STIs) services, Blood safety, Prevention of Mother to Child HIV Transmission, Design, development and distribution of IEC print and electronic
messages and materials, Health education and promotion, voluntary Counseling and Testing (VCT); Care of HIV/AIDS patients at both facility level and community home based care; Provision of treatment for Opportunistic Infections and eventually Anti- Retroviral Therapy; Impact mitigation and support to affected and infected individuals and addressing the stigma, Management and coordination of the health related technical aspects of the national response, Supporting and guiding biomedical and health related research on HIV/AIDS.

Furthermore human resource planning, as important for each Health Centre shall have a communication facility including appropriate transport for referral of patients to hospitals and supervision. Lack of Transport/communication undermines the services to the mothers and children, and is a key factor contributing to high maternal and infant mortality rates. Planning will have to be flexible and responsive to changing needs in the Public, NGOs and Private Sectors. Planning of the numbers and types of health workers will take into consideration health needs, disease burden, workloads, and available financial resource base. However, Human Resource Planning will also focus on curricula studies and other changes and adopt and adapt models and theories related to education and learning.

**Training**

Human Resources Development and Management will be responsible for facilitating pre-service training, in-service training, and continuing education. It will also be responsible for facilitating graduate, post-graduate training, internship and fellowships in collaboration with appropriate authorities, Human Resource Development and Management will oversee the quality of training, registration and re-certification through collaboration with health professional authorities, owners of private health training institutions, the National Council of Technical Education and other stakeholders.
**Funding and Financing Training of Health Workers**
The Government will continue setting mechanisms for funding and financing the training for health workers. The Ministry of Health will continue to review and provide guidelines on cost sharing mechanisms in health training institutions. It will be the responsibility of employing sectors, agencies and other authorities to budget and finance training for their employees.

**Management of Health Training Institutions**
There are several health-training institutions for various health cadres in the country. In order to ensure that they fulfill their mission and goals, sound management and leadership will be ensured. The Ministry of Health will develop and review guidelines for admission, academic progression, completion and certification of health training institutions to ensure compliance to training standards and quality. The Ministry of Health will facilitate the establishment of Governing Boards for each training institution whose composition and terms of reference will be determined.

The Ministry of Health will establish, strengthen and support Zonal Training Centres to offer continuing education, in-service training and distant learning. It will also oversee the training of Health Sector Reform related issues. The Ministry of Health has set up clearly defined priority areas for fellowships and scholarships. It has also established a fellowship committee to select and approve candidates for scholarships and sponsorship. The Ministry of Health will provide and review guidelines for supervision and quality training indicators. It will also conduct internal audit and supportive supervision in the health training institutions in collaboration with the Health Service Inspectorate Unit. The Ministry of Health will ensure that all health-training institutions establish the Medical Training Board.

**Deployments and Retention of Personnel**
The Ministry of Health in collaboration with Presidents Office, Public Service Management (PO-PSM) and Presidents Office, Regional Administration and Local
Government, will set up a clear programme for recruitment, deployment and retention of trained health personnel in appropriate numbers and skills mix. It is important to ensure that deployed staffs are retained in those service areas to ensure sustainable provision of quality health services.

However monitoring and evaluation, the Ministry will ensure that there is a comprehensive and clearly defined operational system of monitoring and evaluation on performance of the Sector. The system must be able to provide decision makers at health facility levels with the following; for evidence based planning and management, Information through the Health Management Information System, Burden of Disease Data, Outbreak and epidemic information for emergency preparedness and disease control, Community-based data to measure the impact and cost-effectiveness of health interventions, Country status of internationally modifiable diseases, Inventory of health care facilities, health personnel and essential drugs, supplies and equipment, Human Resource Management Data and Financial Resources Data.

The Ministry of Health has adopted and will continue to strengthen the following systems for data generation and management within the Sector, The Health Management Information System for routine health facilities data collection, analysis, reporting and utilization, Integrated disease surveillance system for the collection and reporting on communicable disease at all levels including international reporting shall be put in place, strengthened and maintained, National Sentinel Site Surveillance for the collection and reporting of community based information in selected districts.

The goal is to have an adequate number of districts incorporated in the system in order to arrive at reliable National Information on this area, Enhancement of feedback mechanisms to all health care levels. The long-term strategic objective of the Ministry of Health is to integrate the abovementioned systems into the Integrated Disease Surveillance. The Ministry of Health shall provide national standards and
guidelines relating to inter alia; appropriate health care facilities, buildings and equipment.

2.3.1 Community’ perception towards challenges facing health service in rural areas

On the positive front, information obtained from exit interviews with in-patients and out-patients across eight public health facilities in the four regions of Simiyu, Mwanza, Mara and Kagera shows that 90 percent or more of the 200 people interviewed were of the opinion that the cost sharing system had made a “remarkable” improvement in the quality of public health services.

Improvements were seen in the quality of public health services and staff, availability of drugs and laboratory services, and shortage clinic and time (Msambichaka, 2008). This is consistent with evidence gathered from Focus Group Discussions (FGDs) with civil society organizations and local politicians in the four regions which revealed that notwithstanding variations between individual facilities, the introduction of cost sharing had a positive impact on the quality of health services. These results, of course, fail to capture the experiences of people who did not access care at these hospitals.

Provision of health service in villages/ rural areas: it is containing common lack of health facilities, lack of drugs and supplies and also not on informal fees people were required pay. Shortage of skill providers particular located in remote rural areas and the distance, transport as among of problems due to transport lacking and in which communities are poor as evidenced by large number of people living below the poverty line,(Gwatkin, 2003).

Very often, lifestyle-related illnesses are more common in the rural areas. The peaks and troughs of the economic cycle tend to impinge more directly on rural communities, with economic downturns often placing severe pressure on these communities. Consequently, there are significant levels of stress in a situation where
generally counseling, support groups and other mental health services are limited if available at all. Commonly, in rural areas, there is a higher alcohol and tobacco consumption, and standards of nutrition vary when compared with the cities, (Southern Development Community, 2003).

Hutton, (2007), described the human resource situation as a state of crisis. Available evidence shows that public health facilities, in particular those located in the remote rural areas, face an acute shortage of skilled providers. Human resource development will continue to be a critical factor in raising the quality of care.

The dilapidated infrastructure, shortage of trained staff, de-motivated workforce, weak management systems and poor quality of care. In an effort to stem the deterioration of the health system and address systemic financing, service delivery and management concerns, a Health Sector will continue to be a critical factor in raising the quality of care, (Women’s Dignity Project, 2004).

Furthermore predominantly to be controlled due the fact that many public health facilities patients have to share beds while in extreme situations some have to sleep on the floor. Likewise, preventable diseases such as Malaria and Cholera are still claiming lives of many people especially pregnant women and children. Other challenges facing health service delivery include congestion from health facilities and gross violation of professional ethics by health workers which, some of them engage in immoral practices such as soliciting bribe and use of abusive language, shortage of essential medical supplies including medicines, long distances, (Edward, 2006).

Poor working condition, low salaries, lack of motivation tends to reduce the effectiveness and efficiency of many public servants all those hinder to attain or meet the objectives of having well and provision of quality health service in rural areas who can deliver, and all this was caused by lack of morale for work (Jones, 2000).

Poor quality of health services, unavailability of medicines, financial constraints, poor communication, long distance and low awareness levels of the importance of
taking patient for health center is among of challenge to reach the provision of health in rural area, (Mogan, 2011).

Mortality rates for road traffic accidents, asthma, and cancer are worse in rural areas; Cancer is diagnosed at a later stage and intervention rates for coronary artery disease (key government targets for health improvement) are lower. Rural patients are admitted to hospital less frequently than urban patients. Neither the provision of health service in rural needs improvement plan make specific mention of rurality or access, yet if overall healthcare gains are to be achieved, national planners should take note of such a large subset of our population,

Rural healthcare centre needs are not inherently different. Poverty, deprivation, social isolation, drug and alcohol abuse are all features of rural practice, but are compounded by poor access to secondary and village care. The illusion of a rural prevents acceptance of rural practice as an arduous and challenging job, where all aspects of medical and social problems coexist, often concealed by a stoical and uncomplaining public. Furthermore, rural and remote patients are less likely to have the opportunity to exercise choice, a central tenet of government policy. This reduced range and number of service providers, in both primary and secondary care, is a main difference between urban and rural health care. The erroneous assumption of policy makers that a wide range of specialized services is accessible leads to difficulties for rural practice.

Specialist care for the rural patient involves travel and inconvenience unless local services are provided or care is declined or modified. Promoted as potentially higher quality, the centralization of services distances care from rural patients. Health and social inequalities further compound this issue, and are erroneously considered to be a largely urban problem. The need to travel disproportionately affects the most vulnerable, the elderly, the infirm and those with socioeconomic disadvantage, particularly those without cars.
The inverse care law applies as much to geographical access as it does to other forms of deprivation. The travelling burden of rural patients applies to all who receive specialist care. The development of new treatments, examples being psychiatric for acute coronary syndromes and thrombolytic for stroke, may well be outside the reach of all rural patients with current referral pathways. While geography inevitably creates problems, rural need to maintain and develop their roles as local providers either in health centres or in local community hospitals. An attempt to offer equitable access will inevitably lead to measurable healthcare gains.

Access to secondary and tertiary care for rural patients struggles against policy changes based on centralization. Increasing pace of change not only has the potential to improve care but also adds a risk of doing harm, albeit unintentionally. A policy that benefits the urban majority, unless designed and implemented with care may reduce the availability of service to rural and remote patients. Resource allocation already discriminates against rural people trusts. There is no transparency about how complex decisions on resource allocations are made: perhaps this is hardly surprising given the lack of agreement about what constitutes ‘rural’ and the lack of research in, among other things, fundamentals such as deprivation.

A simplistic view of the determinants of ill health being solely due to genetic, environmental or behavioural factors is no longer credible. Social determinants of ill health are the most likely and certainly the most easily remediable causes of poor health. It is accepted that unequal distribution of resources can compound ill health in less advantaged groups. The distributing of resources is a challenge faced by the Tanzania and other industrialized nations, with social change widening rather than reducing social inequalities. In order to achieve equity, distribution of resources should be proportionately weighted towards health services in rural areas, by a combination of sustaining or developing more local services, and adding in mobile or peripatetic facilities.
The new promotional contract is founded on a population-based approach to specific disease areas. The contract is heavily capitation-based, and the provision of essential rural services such as minor injury clinics, immediate care, management of acute illness, terminal care and dispensing have been ignored or left to local negotiation. Many remote practices still provide these services, often unpaid and in addition to their own out-of-hours cover. Such a wide range of services can only be delivered with a low list size.

A combination of poorer health outcomes and fewer resources demands action by any just society. The solution lies in a combination of actions, the first of which is recognition of the problem. The idea that primary care can deliver services traditionally delivered in the secondary sector is a central theme of the Tanzania Paper and there is good evidence that quality will not suffer as a result to die. Introduces the concept of ‘clinical peripherally’ refining the measurement of rural access to medical care. It produces unexpected findings with many island populations having better access to care than substantial mainland communities.

While requiring further evaluation and research, this tool promises to enable managers and politicians to better understand the health provision implications of rural based on reality rather than perception. In turn, this should help to distribute healthcare resources more equitably and allow local rather than centrally imposed solutions to develop. The countryside agency has produced guidelines for ‘rural-proofing’ government policy.

Rural general practice can take on some of the work. It needs support from ministry of health and social welfare and other stake holder care organisations that may not see this as their role. Community hospitals are an under-used resource testing and counseling, however, is successfully delivered to rural communities, showing how much can be done if there is no mobile services and not accepted, and there is a political will.
Mobile imaging units are widely not used to augment urban services throughout the rural, and yet inexplicably they are not used to reduce travel for rural patients. Chemotherapy can be safely and effectively provided at home or in a community hospital, and would significantly reduce travelling, potentially enhance uptake of treatment and improve survival if it were widely available in this form in rural areas. Political and managerial structures to develop the health service provision do not exist, or if they do, are ineffective. The need for good advocacy is both ministry of health and social welfare and overdue. Arguably, our political system is driven by a largely urban agenda, and there can be a tendency to think that technology such as video-links and other new developments will solve all rural problems.

The challenge for the future is for poor provision of health service to engage at a national level with fellow health providers and politicians to achieve improvement. In the past the provision of health service in rural was built on a willingness and ability to address health inequalities. Failing to join together to develop care pathways relevant to rural communities, or further marginalising rural communities by centralising policy, is to miss an opportunity to improve the health of the nation.

2.3.2 Challenges influencing provision of health services in the rural areas

Health provision is growing importance in any sector seeking to gain an advantage among in the community. There is significant debate among stakeholders and scholars as to the effect that health has on both hospitals and organizational goals. One school of thought argues that poor health leads to an increase in disease while the other states that there may be difficulties with recruitment and retention of staff in rural areas. People may be reluctant to accept a short-term post in a distant location, preferring to remain in a larger centre with a wider potential employment pool. Family considerations, such as finding employment for a spouse or higher education for children may play a role. Small units may necessitate unacceptably high on-call commitments, (Eberhardt, 2001 ).
There is often limited choice of healthcare professional in rural areas, and a single example psychiatrist and community psychiatric nurse may cover a large geographical area. Changing psychiatrist may not be a feasible solution to conflict, especially if the patient does not have access to a car. Even requesting a second opinion may be problematic if the patient is unwilling to travel. Problems may arise when more than one member of a family requires psychiatric input from a small mental health team.(Ricketts, 1999).

Working in remote places can lead to professional isolation, and it may be difficult to attend centralized further training. At present in the Africa, for example psychiatric specialist training programmes are all based in urban areas. Rural populations differ in many ways from their urban counterparts. Many features of the rural environment create barriers to healthcare access. It is important for rural health research to include these differences.

Dunkin (2000) Heath services provides a framework for the development of health interventions for rural people. This model takes into account the financial, socio-cultural (or personal), and structural factors that are a part of the complex web of causation in rural health. These factors affect health-seeking behaviors, health service utilization, and ultimately health outcomes in rural areas.

In recent years changes in the kinds of health problems in rural populations have been noted. Vulnerable populations (persons with HIV-AIDS, the aging, those with chronic illness, those mentally ill, and/or abused persons) living within rural areas have compounded issues and added challenges associated with resource disparities and access to care (Aday, 2001).

The supply of healthcare is affected by variables such as technological change, the size of the healthcare industry, and most importantly by demand. Healthcare is a very large industry driven in part by economic incentives and technological change. Progressive industry would not seek to supply services in an area resistive to change.
and utilization of services and without the means to pay for services. As rural residents consume fewer healthcare services, less is supplied. These changes in supply and demand in healthcare perpetuate problems with access to care in rural areas, (Folland, 2001).

The effect of supply and demand is easily seen in the fact that rural people have a lower level of access to both primary care providers and specialized services. Over the past decade a decline in community hospital occupancy has led to the closure of many rural hospitals (Eberhard, 2001).

Consideration of healthcare policy changes over the past decade has drastically decreased access to healthcare services. The rural health environment has felt the impact of these changes in many ways; significant decreases in healthcare services to the already vulnerable, at-risk rural populations have compounded the existing problem of resource disparities. Of noted importance are the drastic cuts in health services created by the Balanced Budget loss of community health services, healthcare professional shortages, rapidly rising cost, hospital closures, homecare cut backs, and tighter government payment schedules are just a few of them, (Makus, 2001).

The authors suspect that the variables that affect the demand for health care in rural areas are income, insurance, and taste (or preferences). Because rural areas have a lower population density and rural residents generally have lower levels of income, a lack of health insurance, and prefer informal care to formal care, the demand for health care is often lower (Bushy, 2000). At the same time an increase in demand caused by a “sicker” population due to greater health status disparities could increase the demand for healthcare services,(Gilson, 2007).

Goodman (2006) had a similar finding in his study of those challenges. He started that Socio cultural factors include cultural and spiritual beliefs, language, education, self-reliance, and concern about confidentiality. Financial factors include a lack of
health insurance, adequate health insurance, or income or financial resources to personally pay for needed health services. He determined structural factors as those factors that have to do with physical accessibility to healthcare resources. They include availability of primary care providers, medical specialist, or other healthcare professionals, and health care facilities. Structural factors are measured in terms of availability and configuration of healthcare services, transportation to them, and distance and travel time to them. Over the past fifty years socio cultural and financial factors that influence healthcare services have received extensive attention, while the geographical factors of healthcare access have received minimal changes that have led to greater resource disparities for rural populations, (Eberhard, 2001).

Healthcare resources and healthcare use vary considerably by level of urbanization because of structural, financial and socio cultural barriers in rural populations. They have fewer healthcare resources than urban populations. Rural resource disparities often lead to adverse health outcomes and rural health status disparities (Fryer, Drisco, et al., 1999; Lovett, Haynes, Sunnenberg, & Gale, 2002; Lin, Allen, & Penning, 2002). Many issues of supply-and-demand are evident in rural populations. Because healthcare is a highly competitive industry in the rural supply-and-demand analysis can provide valuable insight into the relevance of rural health issues.

Rural areas also have lower proportions of all healthcare professionals, often experience diseconomies of scale in that their long run, an average cost increases as output increases, Folland (2001). Providing care becomes too expensive; the providers lose money, and close or merge with other services thereby decreasing access. Rural populations then experience an increase in distance and travel time to access necessary healthcare services. Central to the study of rural health is how “rural” is defined.

Health services provision in Tanzania are constrained by a number of factors in terms of structure, process and outcome ( Kamuzora, 2007). Out-patient department (OPD), the Rural populations differ in many ways from their urban counterparts.
Many features of the rural environment create barriers to healthcare access for rural health research to include these differences. Provides a framework for the development of health interventions for rural people. This model takes into account the financial, socio cultural (or personal), and structural factors that are a part of the complex web of causation in rural health. These factors affect health-seeking behaviors, health service utilization, and ultimately health outcomes in rural areas.

There are a number of well documented barriers to both rural and remote recruitment and retention in the allied health professions, particularly in physiotherapy. These include such issues as lack of career path, isolation, lack of professional and peer support including networking, access and support to attend continuing professional development activities and postgraduate study, lack of remuneration and recognition, staff shortages, and lack of locum availability. Some previous solutions put forward to combat these issues have been localised funding streams successful in some services, but failing to address systemic issues,(Eberhardt,2008).

Barriers to innovation rural and remote areas have the potential to foster an innovative culture for health professionals. There is a lack of available medical specialists, professional colleagues in the same discipline, and other resources which make it important that clinicians adapt to their circumstances through expended scope of practice and innovative models of care. It is because of this, that there is potential for rural communities to benefit greatly from new and emerging practices. Rural and remote communities stand to be leaders in innovative practices that better utilize available health practitioners through extension of scope and practice. In its final report, the Health and Hospitals Reform Commission called some rural and remote communities ‘incubators of innovation’.

There currently exist many barriers to innovative practice including legislation, regulation and cultural barriers. These barriers serve to prevent health professionals from maximizing their contribution to the health and wellbeing of all rural. Rural believes that it is vital that barriers to innovative practice be removed, such as
funding barriers that stop physiotherapists referring directly to medical specialists, as well as state and national Climate change too will affect health outcomes, both directly and indirectly. Already we are seeing the impact of extended drought on the economic base and viability of many rural and remote communities and the livelihood of their residents,(Fragar, 2002).

Found that 63 percent of rural communities, only one out of ten physicians provided healthcare services in rural areas. This statistic means that only eleven percent of this nation’s physicians provide healthcare to 20% of its population (USDA, 2002).

Limitation as experiences specifically geared towards learning, attending a training course and so on or more broadly one’s life experience in general makes one to be confident when implementing the task. But the lack of concrete experience makes one to use just formal opportunities for learning rather than life experience therefore positive and optimistic model of learning opportunities for learning abound. Also the new learning is tried out in practice when a person learning is tried out in practice, when learning at an abstract level is translated into the concrete reality of practice.

Human resource development will continue to be a critical factor in raising the quality of care. Sharing the same view by Women’s Dignity Project, (2004) said the dilapidated infrastructure, shortage of trained staff, de-motivated workforce, weak management systems and poor quality of care in health sector also will continue to be a critical factor in raising the quality of care.

The success of provision of health service depends to a great extent upon the or the resource persons. The providers must know both the activities to be performed by management and how to give treatment to patients. He should have an going attitude to handle different cases and should handle the immediately problems and to apply techniques; also the procedural should be prepared to grasp the knowledge, skills of dealing with different cases (Gupta, 2009).
This step involves action and work through and deciding the different techniques and resources designing support in the process for provision of health services and choosing the appropriate/best techniques may involve specific instructions in the procedures of performing well. (Gupta, 2009).

2.3.4 Strategies to overcome challenges hindering effective provision of health service in rural areas in public hospitals

Management plan is often devised as a way to guide an organization/company through a time of change, and strategic plan implementation can require your operations to break the status quo and undergo radical internal changes. As a strategic plan implementation is essentially a transformation from within, internal factors must be considered, altered and strengthened for success, (Prosci, 1996). Strategy is an arrangement and is interaction among small, medium and large organization which can focuses on planning or implementing. It considers implementation processes and activities or consumptions (Henry, 2004).

Wakerman and Davey (2008), described management plan, Lack of quality and depth of management are significant problems that limit the effectiveness of rural and remote health services Weymouth, (2007). As a critical part of the health team, health service managers should have accreditation and employment requirements consistent with those of other health disciplines. Formal registration or formal qualifications should be required. Support for appropriate education and ongoing professional development should apply to managers as it does to other health professions. Within rural and remote services, where distance management is important, training should specifically ensure managers who are competent in implementing: Careful recruitment in order to select competent, autonomous staffs that have devolved authority. Monitoring systems and effective feedback, Regular lines of communication, Scheduled management visits Periodic 'times out' at head office for staff to ensure consistency and provide pastoral care as needed, Prompt management response as problems arise, As with other health professional groups, health service managers should be formally linked to award conditions and remuneration.
In addition, Specialize for growth with the rapid growth of specialty hospitals, physician-run outpatient surgery centers and diagnostic centers, traditional hospitals are facing increased competition. To compete for patients, hospital administrators must be prepared to set their hospitals apart through a specialized care strategy. Benchmarking best practices is essential; hospital administrators must take time to investigate other specialty healthcare providers in their local communities, identify areas of opportunity and put a strategic plan in place for building renowned specialty practices. During this process, they typically take numerous factors into consideration, including local demographics and competitors' areas of specialization. With a specialization strategy solidified, hospital administrators must focus their efforts on recruiting specialized personnel and building a local reputation for excellence for the practice area, (Brown, 2004).

Service quality and improved co-ordination of care (particularly between primary, secondary and tertiary providers) is reliant on adequate and appropriate information management systems. Evidence-based decision making is critical to improving the efficiency and effectiveness of care. There needs to be an accelerated program of introduction of shared electronic health records across primary health care services, thereby enhancing single point-of-entry activity. Linking capitation payments to reporting will assist on the one hand; training, education and adequate remuneration will facilitate enhanced introduction and use on the other. Monitoring and evaluation of the performance of health services should be integral and ongoing. The ability to report against regional plans and a national rural and remote health plan ensures accountability to rural communities being serviced. In rural areas, lack of high quality national data to allow the linking of inputs, activities, outputs and outcomes is an impediment to evidenced-based health service development, (Sheridan, 2004).

Infrastructure required supporting information technology, communication, quality improvement, care co-ordination, and staffing is crucial. For many remote and small rural communities workforce limitations include lack of accommodation for both community-based and visiting health professionals. This basic infrastructure
requirement should be met with adequate capital infrastructure funding. As well as accommodation, co-location of health professionals and single point-of-entry will assist with better team practice and coordination. Infrastructure should include the use of standard treatment protocols to ensure consistency, appropriateness and quality of practice. Example. Protocols should be incorporated into health information system software. Lastly, practice management is essential to efficiency,(Bayram,2007).

Telehealth and telemedicine, Despite dramatic advances in transport and communications technology, the tyranny of distance remains the single most important impediment for rural people. Tele health and telemedicine (the real time delivery of health and medical services at a distance between two or more locations using technology-assisted communications) have been widely used in rural over recent years as a means of overcoming problems of access to health care and the shortage of health professionals in rural and remote areas. Telehealth encompasses communication(including email, fax, telephone, video-conferencing, e-therapy, online groups); information management(including data bases and internet), and patient assessments and management(including clinical consultations, case management systems including co-ordinating disability services, mental health video-conferencing, virtual clinics, telepharmacy, teledermatology, telepsychiatry, teleradiology, and telepathology). Almost by definition, telehealth shares many of the characteristics of successful outreach or hub-and-spoke arrangements,( Charles ,2008).

Firstly, telehealth can provide a more equitable access to health services in rural and remote area. Through the use of tele-homecare, other home monitoring devices and online monitoring services, for example, advanced technologies can bring services to isolated populations, (Hopkins, 2009).

Secondly, it addresses the maldistribution of medical and health services throughout rural and remote areas. Telehealth services, through the use of telephone, fax (used
at times to transmit x-rays), videoconferencing for psychological consultations, and tele-radiology can compensate for the lack of medical and health services in rural areas. For families with complex and multifaceted needs this could reduce the need for extensive travel, and provide specialist advice and second opinions, (Connor, 2000).

In addition, telehealth can provide opportunities for community development by providing a communication infrastructure. As telehealth and other online services become available, linkages between outlying families and other communities can be established and strengthened. This can promote social aspects of family health, and have important implications for meeting social and psychological needs, (Peterson, 2002).

Bureaucratic barriers, such as outstanding medico-legal issues, remuneration for providers, and patient inconvenience by picking up costs of service; *procedural* barriers such as privacy and confidentiality of clients (including security of client files); lack of infrastructure and inequity of technology access particularly in remote areas, speed of line, equipment failure and internet problems, consistency and compatibility of equipment and standards, oversell by vendors, and issues of image quality and patient safety; and *participant hurdles* such as lack of doctor-patient interaction, intrusiveness of technology coming between workers and clients, dependence on individual clinical champions, lack of acceptance and/or unrealistic expectations of recipients, changes in traditional procedures of medical practice, and the need to ensure that the service respond to needs of rural health professionals and clients and not become just a service initiated from the city (Wakerman et al., 2006). Despite significant government funding and advocacy, there is widespread agreement that the potential of telehealth applications has yet to be realised. Moreover, despite the high take-up rate by many rural and remote areas (especially farmers) of new technology or new forms of communications, the overwhelming preference of most rural areas is still for locally available, face-to-face services. This
dominant preference for local face-to-face interaction has important implications for funders and providers of health related services, (Henderson, 2005).

Transportation, lack of transportation in rural areas is increasingly a barrier to access to health services in rural and remote regions. While it is unrealistic to expect all services, particularly many specialist and allied health services, to be available in all communities, equity of access means not disadvantaging those people living in rural and especially remote areas. The many problems with current patient transport schemes, including out of pocket expenses, lack of support for escorts or careers and inconsistencies across jurisdictions, for rural and remote residents have been well documented. Rising fossil fuel prices have exacerbated many of these problems. National consistency in levels of support provided for patients requiring care away from home is required. The Government can take a lead in developing, (Mutalemwa, 2009).

There also need to be clear national criteria for escorts or careers. With a single national rural, allocation to Regional Health Authorities according to population size, dispersion and remoteness would allow a more efficient local response. Some rural residents cannot afford the upfront costs of travel and accommodation. Regional Health Authorities could issue vouchers prior to travel which would overcome this barrier to access. For some communities, special needs should also be considered. For example, in areas with a substantial Indigenous population, liaison officers may be necessary. Many remote areas have no public transport. Revenue a carbon trading scheme, increased government investment in roads, public transport, and incentives to private transport operators would improve access to a range of services to rural and remote residents. In remote areas, this investment might also decrease the excess motor vehicle accident related deaths and disability in rural areas, (Brown, 2004). Healthy communities and inter sectoral action. Improved health outcomes for residents of rural and remote communities depend on changes and improvements in areas other than health services.
Primary health care takes account of important social, economic and environmental determinants of health outside of the health sector (Turrell, 1999). The revolving door through which we approach health is more likely to involve social, economic, financial and environmental policies than health services. Hence behavioural considerations (including smoking, alcohol consumption, diet and physical activity, risk taking and safety practices), and environment (including social factors such as education, occupation and the working environment, the living environment, culture, (Hayes, 1986).

Social networks and support, as well as physical factors such as housing, water and food quality, efficient sewage disposal, and other physical environmental hazards) assume great importance. Throughout rural and remote many communities are struggling to overcome their existing populations, let alone to increase their size. The impact of economic restructuring on the rural sector, market fluctuations, climatic vagaries, the rationalization of public and private services, and the associated process of rural depopulation means that many rural and remote communities must be done and maintaining existing health services for the future, the drivers of regional development and regional decline are critical considerations for health service planners, (WHO, 2006).

The sustainability of many small rural and remote communities is in question. The impact of climate change, resultant changing rainfall patterns and water availability, and rising oil costs on many agricultural communities has been profound. Erosion of their traditional economic base and de-population calls into question the viability of these communities. This has implications in terms of new opportunities for economic development (such as improving land management practices and tree plantations within a carbon trading scheme), as well as implications for health services.

At the same time, all primary health care services should be encouraged in rural areas to link with and advocate for other relevant sectors such as education, environmental services, employment programs etc. Health professionals can be powerful advocates,
especially in smaller rural and remote communities. Improved infrastructure and robust IT systems can facilitate employment in non-metropolitan locations. Local employment in the health sector also contributes directly to these upstream determinants. A detailed action plan for change is beyond the scope of this paper. Nevertheless, given the need for significant systemic change related to these various interlinked components, it is reasonable to expect a description of the next steps and a timetable for change,(Gawanas, 2008).

Timetable, optimal rural and remote health requires some form of public intervention since many of the influences adversely affecting the health status of rural and remote communities reflect shortcomings associated with dependence on the market place. For this reason health planning plays a critical role in determining the availability and use of resources in relation to health needs. Health planning incorporates both formulation and implementation of policies. Policy (the framework of principles and objectives that guide decision-making and activity) must be accompanied by explicit strategies to guide the process by which scarce resources are allocated in order to achieve specified goals and objectives, (Anyangwe, 2007).

A successful planning strategy incorporates consideration of what is feasible in terms of resources and technical considerations as well as taking account of the opportunities and constraints characterising the broader political context. Pre-requisites for successful implementation of policies include flexibility in order to cope with changing circumstances, adequate consultation and involvement by all those affected, suitable co-ordination of activities, careful timing, and monitoring throughout to ensure that objectives are being met and in order to avoid unintended effects. In reviewing progress of rural and remote health policy it is apparent that all too frequently good intentions never materialize into action.

Despite many (often uncoordinated) initiatives, programs and policies relating to health in rural and remote communities over the last fifteen years, the health care needs of many rural and remote continue to be neglected. The effect of implementation failure is that it often engenders considerable cynicism among target
groups in relation to health. In addition to making changes in the education of medical professionals, governments have provided incentives to recruit and retain staff in rural areas.

Validity as human service delivery should be valid when health services reached to target group, reflective observation opens the door for a broader and deeper consideration of the issues arising from one’s experience. The health service delivery should be relevance and validity.

Many public health facilities patients have to share beds while in extreme situations some have to sleep on the floor. Likewise, preventable diseases such as Malaria and Cholera are still claiming lives of many people especially pregnant women and children. Not only that but also congestion from health facilities and gross violation of professional ethics by health workers which, some of them engage in immoral practices such as soliciting bribe and use of abusivelanguage, shortage of essential medical supplies including medicines and long distances,(Edward, 2006).

Highly skilled doctors and nurses are not available in large enough numbers to provide services to the majority of clients, especially in rural areas. One solution to address this is task shifting to well-trained lower-level cadres of service providers for example, clinical officers and nurses instead of doctors, particularly in remote areas where it is difficult to get better-qualified health professionals to practice. These cadres typically require two to three years of postsecondary training, rather than the five to six years required for medical doctors rapid-response staffing and training model designed to increase the number of qualified health professionals available to work in public health facilities expand access to treatment and care through rapid hiring, training, and deployment of health workers.

In using quality improvement methods help provider teams to identify barriers, providing effective and efficient health care and to develop solutions to these problems. This approach has led to more motivated staff, improved service delivery
systems, and improved care outcomes. Examples of programs that have utilized this approach with subsequent improvements in staff capability and outcomes are presented on the some of the improvements achieved by these programs include decreased postpartum hemorrhage, improved compliance with standards of care, improved adherence to antiretroviral (ARV) medicines, better triaging of children with serious illnesses, and better outcomes of emergency care, such as reduced deaths within 24 hoursof admission. Importantly, these improvements have been made by changing the process of care delivery and without increasing the number of health-care worker (Gideon, 2005).

2.5 Research gap
Many researches have been conducted by various researchers in Tanzania and East Africa at large, about Challenges facing provision of health service in rural areas both private and public sectors. Among of them are; MoH (2003), (Edward 2006), Women’s Dignity Project, (2004). However, no one has investigated the challenges facing provision of health service in rural areas especially at Ngasamo village, the area which I conducted my study.

2.6 Conceptual frame work

Source: Researcher’s data (2013)

Figure 1: Effective provision of health service which improve the public sector performance
Identifying gap: Is the situation of identifying the weakness and challenges from the management and individual or employees both private and public health service sector before deciding to impart, and develop specific skills, knowledge and attitude according to the provision of health service in rural areas, (Prasad, 2009).

By using procedure and quality improvement methods to help provider teams identify barriers to providing effective and efficient health care and to develop solutions to these problems. This approach has led to more motivated staff, improved service delivery systems, and improved care outcomes. Examples of programs that have

Selecting the target: In this situation it is necessary to decide who should be providing health service in rural areas? This may be new patients in the hospital. The type and methods to be used will depends upon the type of persons to be provided service, it is also necessary to create desire for service (Ngirwa, 2006).

**Preparation of good administration:**
Knowing how to properly align groups of personnel with organizational strategy is a key component of a well-managed health programme. A delicate blend of organisation, staff monitoring, and communication amongst all partners is necessary when dealing with diverse teams of people. Be a leader that brings measurable changes within your health programme through a comprehensive approach to performance management.

By mastering leadership skills, participants will be able to direct and influence any group of personnel in or outside of an organisation. Senior experts in public health and management training integrate lectures, role-playing scenarios, and work simulations that guide participants through critical questions and effective solutions in advanced management training.
• Create measurable results in a TB and HIV programme through long-term planning
• Implement changes in an organisation that build greater staff commitment, competence, and confidence
• Achieve higher success rates through enhanced team performance
• Enhance your ability to communicate assertively
• Build personal relationships that can optimise performance
• Master the principles of staff development like providing feedback, coaching, and mentoring
• Properly assign personnel in order to better plan and execute strategy
• Improve productivity of staff.

The success of provision programme depends to a great extent upon the /or the resource persons. The providers must know both the activities to be performed by management and how to give treatment to patients. He should have going attitude to handle different cases and should handle the immediately problems and to apply techniques; also the procedural should be prepared to grasp the knowledge, skills of dealing with different cases (Gupta, 2009).

Identify new technology
The general public believes that new technology will improve health care efficiency, quality, safety, and cost. However, few people consider that these same technologies may also introduce errors and adverse events, types of medical devices are used by millions of health care providers around the world, device-related problems are inevitable. While technology holds much promise, the benefits of a specific technology may not be realized due to four common pitfalls: (1) poor technology design that does not adhere to human factors and ergonomic principles, (2) poor technology interface with the patient or environment, (3) inadequate plan for implementing a new technology into practice, and (4) inadequate maintenance plan.
For example, patient care technology has become increasingly complex, transforming the way nursing care is conceptualized and delivered. Before extensive application of technology, nurses relied heavily on their senses of sight, touch, smell, and hearing to monitor patient status and to detect changes. Over time, the nurses’ unaided senses were replaced with technology designed to detect physical changes in patient conditions. Consider the case of pulse oximetry. Before its widespread use, nurses relied on subtle changes in mental status and skin color to detect early changes in oxygen saturation, and they used arterial blood gasses to confirm their suspicions.

**Implementation**: Highly skilled doctors and nurses are not available both in urban and village health centres must be sent by government also must be developed enough numbers of health providers to provide services to the majority of users, especially in rural areas. One solution to address this is task shifting to well-trained health providers for example, clinical officers and nurses instead of doctors, particularly in remote areas where it is difficult to get postsecondary training, rather than the five to six years required for medical doctors. Rapid-response staffing and training model designed to increase the number of qualified health professionals available to work in public health facilities expand access to treatment and care through rapid hiring, training, and deployment of health workers.

This step involves action and work through and deciding the different techniques and resources designing and support them in the process for provision of health services and choosing the appropriate best techniques may involve specific instructions in the procedures of performing well. (Gupta, 2009).

**Monitoring**: This dealing with the techniques and procedures implemented, here the providers try seeing if there is any success or failure, if there is any failure the providers and other stakeholders will make restricting in order to overcome different failures and illustrates in order to put the new implementation. However, in the process of monitoring it needs to evaluate if there is any success showing it is better to terminate the project. (Armstrong, 2009).
**Follow up:** In this step, the effectiveness of the provision of the service programme is assessed, the feedback generated through follow-up will help to reveal weakness or errors if any, necessary corrective action can be taken, if necessary instruction may be repeated (Ngirwa, 2006).
CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Introduction
Research methodology is a systematic way of solving the research problem. In it, we study various types which generally adopted by a researcher in studying his/her research problem along with the logic behind them. It is necessary for a researcher to know not only the research methods or techniques but also the methodology (Kothari, 2003).

This chapter presents a study area, research approach design, study and population, data collection instruments/methods data analysis plan sample size, sample techniques, purposive sampling, simple random sampling, primary data, secondary data, data collection method, interview method, internet search method, documentary analysis method, data collection instruments, self-administered questionnaire, focus group discussion, documentary review guide and data processing and analysis.

3.1 Area of study
This research was conducted at Ngasamo village in Busega District because Ngasamo village is facing a problem of poor provision of health service. Therefore, large number of people from different areas depends at Ngasamo health centre for medical treatment. Also there is availability of data from Ngasamo health centre.

3.2 Research approach and Design
This study used two research approaches namely; quantitative and qualitative approach. Quantitative research involves the generation of data in quantitative form which can be subjected to rigorous, quantitative analysis in a formal and rigid fashion. Qualitative approach to research is concerned with subjective assessment to people’s attitudes, opinion and behavior. Therefore, these approaches generated
results about the contribution of effective formal or in informal which are not subjected to rigorous quantitative analysis.

Research design is the arrangement of condition for collection of data and analysis which aim to combine the relevance of research purpose. Kothari, (1990), research design is a master plan specifying approaches and strategies for collecting and analyzing required information Zikmud,(2000), cited in Mahemba, (2003).

In this study, a case study design was used to provide an in-depth analysis of health service delivery. This research design allows a face to face discussion. Such discussions provide an opportunity to have a deeper understanding of a person’s beliefs, feelings and behaviors on important issues.

3.3 Study population
According to Crowl (1993), population is defined to mean group of people which the researcher is interested in gathering information from, the respondents as well as drawing conclusions regarding the whole population. The study population of this study comprises the whole community members from Ngassamovillage who were selected by the researcher.

3.4 Sample Size
Shipman (1992) define a sample size is a unit of individuals that is small size to present the population from which it was selected. A sample is a definite part of statistical population whose properties are studied to gain information about the whole community members (Webster, 1985).

Researcher has been optimistic so that the sample size should neither be excessively large nor too small, also has been considered parameter of interest in order to satisfy the requirement of efficiency, representatives, reliability and flexibility. Since it was difficult to cover the whole community members at Ngasamo, the researcher interviewed a total study covered a 100 respondents.
The sample size of this study consisted of one hundred respondents (100) namely (10) doctors from different health center at Ngasamo village, (10) nurses who know the Management from different Departments and (10) local leaders were interviewed and (70) community members both female and male were provided questionnaires. The sampling techniques used in this study were purposive and random technique. The purposive sampling was used to get number adequate representative while simple random sampling applied to get respondents from the local leaders and community members. The researcher organized four groups of respondents that is (20) respondents who were doctors and nurses, (10) who were local government leaders and (70) community members. (See the table 3.4.1).

**Table 3.1  Sample size**

<table>
<thead>
<tr>
<th>S/N</th>
<th>Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Doctors</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Nurses</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Local government leaders</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>Community members: Female</td>
<td>35</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source from the field data, 2013*

**3.5 Sampling techniques/procedures**

Kothari (2004) indicates two basic ways of choosing a sample technique sometimes referred to as a type of sampling. Therefore sampling techniques that were used in determining a number of respondents that were involved in the study so as to provide necessary knowledge. In this regard purposive and random sampling techniques has been used in determining the required sample size (100) of the study.
3.5.1 Purposive sampling
According to Cooper et al (2003), purposive sampling is sometimes known as judgmental sampling, the researcher chooses only those elements which he/she believes to be able deliver the required data. In this regard respondents have been selected purposively according to their position such as Doctors, nurses, local leaders. The purposive sampling is useful in this study because it is less expensive and quick for selecting a sample size (Smith, 2000).

3.5.2 Simple random sampling
The simple random sampling refers to a probability sampling whereby all members in the population has equal chance of being selected to form a sample size (Saunders et al, 2000). This helped the researcher to select a sample size at random from the population. Each villager member was picked randomly to make a sample size.

3.6 Sources of data
In this study both primary and secondary sources were used to gather information.

3.6.1 Primary data
Primary data are always collected from the source. It is collected either by the researcher himself or through his agents. Here the researcher directly contacts the informants, solicits their cooperation and enumerates the data. The information are collected by direct personal interviews. The novelty of this method is its simplicity. It is neither difficult for the respondents nor the informants. Because both are present at the spot of data collection. This method provides most accurate information as the researcher collects them personally. But as the researcher alone is involved in the process, his personal bias may influence the accuracy of the data. So it is necessary that the researcher should be honest, unbiased and experienced. In such cases the data collected may be fairly accurate. However, the method is quite costly and time-consuming. So the method should be used when the scope of enquiry is small (Kothari, 2004), here it is noted that the researcher direct were collected data from Ngasamo heath centre.
3.6.2 Secondary Sources of Data

Secondary data is any information that has been collected or researched recently. Sources of secondary data include the internet, libraries, museums, company reports, newspaper etc. The data collected is useful as it allows the researcher to see the prevailing thoughts about his/her area of study. Secondary data is any information collected by someone else other than it's user. It is data that has already been collected and is readily available for use. Secondary data saves on time as compared to primary data which has to be collected and analyzed before use, According to Kothari (2010).

Secondary data helped the researcher to identify the gap from previous studies which have been carried out by various researchers on the same study. The data also helped the researcher to know how other countries overcome the similar challenges.

3.6 Data Collection Methods

The central focus for any research activity is the gathering of information or data for the production of knowledge. Leedy (1974) defines data as those facts that a particular situation gives to an observer. In this study the researcher used interviews, questionnaires, documentary reviews and web survey for data collection so as to get the desired information which cross-checked from different sources. In this study semi-structured and in-depth interviews, secondary data reviews, web and were applied as data collection methods and structured questionnaires as data collection instrument.

These are methods used in gathering primary and secondary information for the purpose of this study. The task of data collection begins after a research problem has been defined and research design/plan chalked out. In this study the researcher used the following methods to obtain both primary and secondary data which was; interview method, documentary analysis, internet search and observation method.
3.6.1 Interview method
Kothari (2004) defines interview method is a method of collecting data which involves presentation of oral-verbal stimuli and reply in terms of oral-verbal responses. This method was been used through personal interviews.
Here the researcher prepares 'a small list of questions relating to the enquiry. The answers (information) are collected by interviewing persons well connected with the incident. The researcher should cross-examine the informants to get correct information.

This method is time saving and involves relatively less cost. The accuracy of the information largely depends upon the integrity of the researcher. It is desirable that the researcher should be experienced and capable enough to inspire and create confidence in the informant to collect accurate data.

Also the researcher used personal interview method in the study due to the following due to get; more information and that was too in greater depth to be obtained; interviewer by his own skill had overcome the resistance, there was greater flexibility under this method as the opportunity to restructure questions was always there, especially in the case of unstructured interviews; person information was obtained easily under this method; sample was controlled more effectively and the interviewer collected supplementary information about the respondent personal characteristics and environment which was often of great value in interpreting results. In this researcher used interview method by interviewed nurses and few nurses in order to save time and to get correct information to respondents.

3.5.2 Internet search method
This refers to the use of online resources to gather data for research purposes, requires appropriate citation and critical analysis for findings. The method was employed in order to obtain the secondary data by searching the information related to the study only. The method was useful because; it is faster, better, cheaper and easier to obtain the required information (Schalk, 2000).
3.6.3 Documentary analysis method

Is a technique used to gather requirements during the requirements elicitation phase of project. It describes the act of reviewing the existing documentation of comparable business processes or systems in order to extract pieces of information that are relevant to the current project and therefore should consider projects requirements (Smith, 2000).

This method is valuable due to; it replaces one or two existing systems with a new system that were offer increased functionality, existing documentation can be scoured for an understanding of key functions, business rules and business entity attributes, and is also necessary when stakeholders are not available to offer insight into existing business processes or systems.

Therefore the researcher was spend some of his time at the study area exploring statistical data, plain reports (quarterly reports, annual reports, evaluation reports, specific reports, monthly reports) and performance reports in comparing different periods of performance (Smith, 2000).

3.7 Data collection instruments

These are the instruments used in obtaining primary and secondary data. The researcher used the following instruments which are interview questions, questionnaire, and documentary review guide.

3.7.2 Self-administered questionnaire

This is a very commonly used method of collecting primary data. Here information are collected through a set of questionnaire. A questionnaire is a document prepared by the investigator containing a set of questions. These questions relate to the problem of enquiry directly or indirectly. Here first the questionnaires are mailed to the informants with a formal request to answer the question and send them back. For better response the investigator should bear the postal charges. The questionnaire should carry a polite note explaining the aims and objective of the enquiry, definition
of various terms and concepts used there. Besides this the researcher should ensure the secrecy of the information as well as the name of the informants, if required.

Success of this method greatly depends upon the way in which the questionnaire is drafted. So the investigator must be very careful while framing the questions. The questions should be Short and clear, Few in number, Simple and intelligible, Corroboratory in nature or there should be provision for cross check, Impersonal, non-aggressive type, Simple alternative, multiple-choice or open-end type, (Kothari, 2005).

The questionnaire method is very economical in terms of time, energy and money. The method is widely used when the scope of enquiry is large. Data collected by this method are not affected by the personal bias of the in researcher. However the accuracy of the information depends on the cooperation and honesty of the informants. This method can be used only if the informants are cooperative, conscious and educated. This limits the scope of the method.

This method were applied by the researcher supplied questions to community members, and nurses who were busy in order to get equal chance to participate in given the information .

3.5.3 Observation Methods
Through observation information was also gathered and analyzed by the researcher. The researcher was actively involved as participant observer. The researcher observed various Doctors and nurses the way they provide health services and general working environment of employees’ attitude towards provision of health service. In observing the activities and staff behavior it helped the researcher to acquire relevant information as far as the study was concerning. Participatory observation enabled the researcher to see how patients are treated by workers while performing routine activities of the health centre and thus helped in evaluation of their activities in relation to the environment.
3.5.5 Focused Group Discussion

A focus group discussion (FGD) is a good way to gather together people from similar backgrounds or experiences to discuss a specific topic of interest. The group of participants is guided by a moderator (or group facilitator) who introduces topics for discussion and helps the group to participate in a lively and natural discussion amongst themselves. The strength of FGD relies on allowing the participants to agree or disagree with each other so that it provides an insight into how a group thinks about an issue, about the range of opinion and ideas, and the inconsistencies and variation that exists in a particular community in terms of beliefs and their experiences and practices, (shamdasan, 1990).

Focus group discussion can be used to explore the meanings of survey findings that cannot be explained statistically, the range of opinions/views on a topic of interest and to collect a wide variety of local terms. In bridging research and policy, FGD can be useful in providing an insight into different opinions among different parties involved in the change process, thus enabling the process to be managed more smoothly. It is also a good method to employ prior to designing questionnaires, (stewart, 2004).

A facilitator guides the discussion around the particular topic. Group members are able to say what they think and respond to the views of others. Focus group can be used for generating and exploring a range of ideas and attitudes for gaining an in-depth understanding, when there are time and money constraints with people who may have difficulty completing written questionnaires to clarify and follow-up on ideas, issues and attitudes that have been mentioned during the focus group discussion. It can provide with quick, low cost methods of generating ideas and identifying, priorities, (Yield, 2006).

The method used to few village members, doctors and nurses who are living at Ngasamo village and who understand well the real environment of the health centre. The researcher organized and conducted focus group into group of eight participants.
3.7.6 Documentary review guide

It is an instrument used in the collection of secondary data. The guide will follow the following steps in reviewing the documented materials (Smith, 2000).

- External analysis of the document, which is the classification of the document of authors’ name, time of document, place of document being produced. Category of the document, the intended audience of the document
- Internal analysis of the documents involves analysis on the content of the document and believability of the document
- Evaluation the evidence (conclusion)
- Some of the importance of existing document can be scoured for an understanding of the key functions, of business laws and business entity attribute, it offer insight in two existing business process or system, and it can replaces the one or two of the existing system with the new system that will increase functionality (Trochim, 2006).

3.8 Data Processing and Analysis

The analysis of data involves computation of indices and measures to determine the validity of data and indicate any conclusion,

Data analysis is very important step towards finding solution of the problem under study. Kothari, (2000:122), describes data analysis ‘as the computation of certain measures a long with searching for pattern of relationship that exist among data group.’

Data processed and analyzed by using Microsoft excel. Microsoft Excel is a spreadsheet program which allows one to enter numerical values or data into the rows or columns of a spreadsheet, and to use these numerical entries for such things as calculations, graphs, and statistical analysis. The outputs are presented in Tables, figures and text to simplify interpretation.
CHAPTER FOUR
PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction
This chapter presents analysis and discussion about the findings from the collected data guided by research problem, research objectives and research questions outlined in chapter one. The chapter is organized as follows.

4.2 The community’ perceptions towards provision of health service at Ngasamo village
Respondents were asked to describe their perceptions on the provision of health service in ngasamo. This illustrated below by the perception on villagers, local leaders, and health workers perception.

Here, researcher was interested to know the types of health service provided at Ngasamo health center whereby all respondents asked the question to mention the types of heath service ,provided by Ngasamo health center, many respondents mention the common answer were maternal and child health care treatment, offering basic laboratory, malaria and dental service.

Other 20 percent of 35respondents also answered that conduct therapy for tuberculosis patient. A few respondents mentioned that women have special needs related to pregnancy and childbirth and children require immunization against common disease, including measles, poliomyelitis, tuberculosis, diphtheria, tetanus, whooping cough. Most of the respondents appreciated the health services provided at Ngasamo even though the village is being allocated far from the center.
Therefore other service provided at Ngasamo village hospital was not mentioned. All these answers reflect the real situation of village hospital also the result of the opinion of the village members.

Through interview with local leaders one of respondent said, ‘it is true that health provision in village prevent, treatment and management of illness and the presentation of mental and physical well-being through the service offered by the medical and allied health profession has improved the quality of services although not that much but somehow the quality of services delivery have been improved.

Kwesigabo (2005), argued that in any community where by communicable diseases are common such as diarrhea, malaria, HIV/AIDS as problem and it needs care and treatment.
Through focus group discussion, only 40 percent of respondents mentioned that, family planning, treatment of infectious disease like diarrhea, malaria, curative care for sick children and for sexual transmitted infections disease, service for pregnant women and maternal care mentioned that as the among of the service provided to patient at ngasamo health center.

*Basing on the findings above indicate that village members knows the importance of provision of health service at Ngasamo village as it brings improvement of service and efficiency thus why most community members prefers seeking service in order to improve individual absence of disease.*

“One respondent said, we are happy that through health service provision at ngasamo village, members have delivery efficiency services have been improved life standard.”

Health Services consist four main concerns were raised that relate to health services. First, health workers complained of the bad timing of clinic in relation to the season and people’s daily activities. They said during the day it was too cold at times and some health workers preferred to stay home instead of reaching in the health center. They said: “It is too cold for children … sometimes you have to wait a long time for them (health workers) to come …” (FGD-1 Mage), “… why is it held in the cold season? It’s cold to walk all the way from home and to come and queue up at the health center for a long time.” (FGD-2)

In addition, when it rained it was difficult to visit health center for health provision, the rains or on the muddy roads, as expressed in the following quotes: “… we, the nurses, are too tired, we spend all our time in the health centers …,” “… sometimes it’s impossible to come to the work even for a day because bad season.” (FGD-2), “… if it rains very few health workers will walk in the rains to take care patient for child health clinic, especially if the children are older and are fully vaccinated …” (FGD-2), “… caretakers want to go for child health clinic, but it’s inconvenient to walk in the mud and difficult to cross our stream if it’s just been raining” (FGD).
The findings conquer with masaga, (2006) who supported that health service provision improves and develop present Tanzania health care system.

Source from field 2013: Ngasamo health center patient are register for health service

It indicated that the most common illnesses among children under five years in rural area are fever flu, and cough; children have had these diseases in each village. Diarrhea is very common, to community have suffered from diarrhea, the incidence of measles in children under five years who have been vaccinated.

Data also show that children under five years the highest incidence of measles, pneumonia was more troublesome. children are considered fully vaccinated when they have received a vaccination against tuberculosis (BCG), three doses each of the DPT and polio vaccines, and a measles vaccination by the age of 12 months, percentage of children under who had received a vitamin A supplement, World Health Organization (WHO).
However, malaria was the most frequently identified as a type of health problem by participants both male and female during focus group discussions (FGDs); malaria was identified on average 5.25 times per village. Other health problems or diseases frequently mentioned included: pneumonia, typhoid, diarrhea, sexually transmitted diseases, and tuberculosis.

The Health Officer said that the most common causes of illness in the village over the past 12 months included a lot of mosquitoes during the rainy season, not boiling drinking water.

In addition, the Ministry of Health is implementing the various programmes to curb communicable diseases including cholera, malaria, and diarrhea diseases. There are also plans to reduce HIV infection levels and implementation of family planning programmes.

Source field 2013: pregnancy women receiving SP for malaria prevention.
Also, it was recognized that illness could be acute and serious requiring attention depending on the perceived urgency. Conditions that were identified as needing conventional care include 'vomiting in children, convulsions, "pressure" (hypertension), "ulcers" (chronic epigastric pain), dental problems, cough and chest pain, epilepsy, diabetes, malaria, and measles'.

And yet, the perception that traditional care or faith healing was the norm for some conditions might deter conventional healthcare utilization for all wealth categories. This is illustrated in the quotes below:

‘Artificial medicine for "maviyatembo" (condition where child presents with chills and cold spells), "mkojo" (convulsions), "syphilis" and sexually transmitted diseases is inferior to local medicines.’ (FGD.).

Also 'Some types of balokole (born-again Christians) just pray for conditions like fever, snake bite, diarrhea, serious fall from a tree' (FGD).

'It's not easy to prevent malaria because even if you say you want to buy a mosquito net, you won't put it on when you are outside of the home conversing’ (FGD, Sami).

What are the types of health services are being provided in the villages hospital (mention)

1. Care of children.
2. Family planning.
3. Treatment of infection
5. Children required immunization to common disease including measles, poliomyelitis, tetanus, whooping cough.
6. Maternal and child health care treatment
7. Offering basic laboratory
8. Malarial
9. Dental service.
10. Convulsions
11. HIV/IDS counseling

Source: researcher student 2013
In other hand 11 percent of the respondents said there is no types of health services provision at Ngasamo village, rejecting the 89 percent of respondents who admitted that there are types of health services provision, this few are those village members and local leaders in the village, thus why they failed to see the types of provision for health service at Ngasamo village.

4.3 Challenges that hindering effective provision of health service at Ngasamo village.

Here the researcher was interested to know the challenges hindering provision of health service at Ngasamo village. Most of doctors, nurses, local government leaders and village members gave out their responses as following:

Only 10 percent respondents who were village members aged 30 to 60 years old said that Lack of equipment and unreliability of supplies was one of challenges in provision health services. They argued that there is a chronic shortage of equipment and supplies (including vaccines, antibiotics, and other essentials) compounding poor quality of services at village health center. Irregular supply of essential drugs at all levels of the health delivery system leads to unnecessary referrals, Problems with hygiene are regularly encountered, particularly in dispensaries and health centers where water supplies are often non-existent, erratic, and unsafe.

Even though 'the health center works only for twelve four hours, there are always stock-outs, and health personnel are very rude and tough. No ambulance, poor referral system. Sometimes they delay to refer patient to the hospital and may hold patient only to tell after a long time for example 6.00 pm when you can't do much. There is only one bed for maternity, few staff, they always insist to go by the book, may require you unnecessary details and credentials, etc.' (FGD Katwale).

Contrast, studies described by Junwa, (2008), pointed out that the government hospital lack supplies compromised and perceived inadequacy of services even for the least poor as they found it unrealistic to purchase medicines from the private source. There is a lack of medicines in government hospitals.
Another marked that many rural health care systems, small rural health care providers especially hospitals cannot afford the equipment and personnel necessary to treat the entire array of modern diseases and injury, Coronary bypass surgery, artery repair, advanced trauma care, and other complex procedures require specialized medical teams, equipment, and facilities. Such resources are economically viable only in hospitals and surgical centers with high volumes of patients. Consequently, rural residents must often travel great distances to access more costly and complex levels of care, (Gawanas, 2008).

Despite this, 15 percent of respondents explained that many health workers Lack supervision and low motivation are among of the challenges hindering provision of health service at Ngasamo. This aligned with the argument that in village health workers often go months without supervision, and reports about its quality service, from helpful although infrequently to unsystematic and unfriendly, Consequently, there is often low motivation to comply with standards, Low motivation also produces problems with absenteeism, and absenteeism rates are high,(Tibandege,2004).

One of respondent said during interview supervision to village doctors and nurses does not appear to be as effective as it could be. Village workers complained that the outcome of supervision by township staff sometimes influenced the amount of subsidy they received and township directors mentioned that supervision can be difficult to conduct.

Other studies confirmed difficulties in supervising village clinics as acknowledged that public health services are weak in villages partly because of limited supervision,(Levis 2007).

However 12 percent of respondents mentioned poor transportation and communication as the challenge in health provision which result into inadequate communication between health service providers at the various levels means that
provider skills and facilities are not maximized and that it is difficult to organize referrals and feedback through the various levels of the referral chain. Long distance to the health center was one of the challenges that emerged from the discussions as being a major difficulty to attending clinic among the women.

They said that the distance was too long for some mothers and it was difficult or impossible to carry all children with them. It was particularly tiresome with bigger children that were heavy to carry and at the same time could not walk on their own all the way. For example they said: “... some of our homes are very far from either the health center, and it’s difficult to walk all the way with a child on the back, especially if you’ve been working ...”.

It was a common practice to stop taking children for clinic who are aged 2 years and above. This was due to the fact that at 2 years the child would have been fully vaccinated and only went to the health center to receive antihelminthic drugs, vitamin A supplementation, and for growth monitoring. This and the fact that older children were heavier to carry compared to younger ones were important factors. One woman said: “... it is a common practice for parents to stop taking children who are 2 years and above ... maybe they think vitamin A and deforming are not important.” (FGD).

Similarly, children who are no longer breast-feeding are also not consistently taken for clinics in a number of cases. It is believed that a child who has been weaned will have developed a strong body to fight diseases and therefore do not need to rely on medication so much.

‘Our local health care options are near – some illnesses need first aid. For example acute illness such as convulsions, if a child has convulsions, we go to drug shops and private clinics because they are the nearest and also because we may not have transport to get to another facility' (FGD).
Distance from clinics and hospitals and poor infrastructure creates a physical barrier to obtaining care, which is not easily overcome due to a lack of transportation services. This is particularly true for those living in the rural areas. Surgical services are much more available in urban areas, while the majority of patients needing care are located in rural locations. In rural Africa, distance to the hospital was cited as the most important barrier to surgery, (Frenk, 2006).

One of respondent argued that poor infrastructure, geographic isolation leads to problems of access to care and to a shortage of health care providers and health services, particularly in small, sparsely distributed populations. The health of indigenous people, who constitute 3% of rural populations and 13% of remote populations, was found to be much poorer than that of all other village. Low salaries, frequent unavailability of necessary equipment and consumables, inadequate performance evaluation and feedback, poor communication channels in and among units and between workers and management, lack of participation in decision-making processes, and a general lack of concern for workers welfare by the hospital management, (FGD).

Not only that but also community medicine distributors make it easy for us to access health provision care but these are unreliable (FGD).

Inaccessibility of some areas, especially during the rainy seasons, was also challenge making it difficult to both for health staff patient to deliver patient for clinic to central places like the dutwa, tunzu, and Ramadi, (FGDs).
Source from field 2013: poor infrastructure to reach health service. Another challenge is lack of trust in the health worker qualifications particularly in the public hospital clinics and hence the efficacy of the treatment given. 15 percent of respondents explained on this challenge.

Most of the respondents especially women when interviewed said that *The health workers treat us badly like we are not human beings, they may not even be bothered if someone dies compared with the traditional birth attendants who treat people humanely. In hospital they slap you and say "to avoid disturbances let's do the caesarian operation". This brings fear and skepticism in using the service. If you have grown up in poverty you may look older than you actually are and they will abuse you and say that "look that old woman who has come to give birth"* (FGD). *In our (public) clinics, we do not know the qualifications of our health workers. You can't ask them where they obtained their qualifications from, so long as they give you some treatment. For some conditions like severe anemia – these public health services cannot be useful yet you cannot afford referral. When you have fever you go for medication whatever it is. It could be chloroquine mixed with Aspirin. We are not
sure whether it helps or not is another matter. You can't be sure that what you are getting is effective but we have no other option' (FGD).

Lack of medicines at the health centers is also challenge of providing health service in Ngasamo health center. These responses emerged from FGDs as well as interviews conducted with community health workers and health personnel at both the health care providers and the users. They agreed that medicines were not adequately available. Two main factors were cited as major causes, large catchment population and erratic drug supply from the health centers, health office especially in the six months preceding the interviews (reported by health workers).

The women in four FGDs thought the catchment populations were too big for the clinics to provide adequate services. One of the women (FGD) said: “there are too many people in our area and as a result the medicines are always not enough.” Health workers from both health centers reported an erratic supply of drugs that resulted into inconsistent availability of the drugs to patients. Similarly, patient expressed concern on the inadequate quantities of medicines they were given. They received medicines every three months but the medicines only lasted for a month.

However 8.8 percent of respondents mentioned that in rural health center fear of stigma as challenge to use of some public health services.  

It observed that there are illnesses that we don't take to health units where we have someone known to us. Like HIV/AIDS, here we just go to witch doctors. In fact, we don't even want to know that it's AIDS. We prefer to be told that it is witchcraft. People fear to give advice when they see signs of AIDS. They are afraid because that would be offending the sick, people shall ask you how you know ... how you come to imagine that it's HIV. When you mention testing to them, they will shun you and never want to talk to you again' (FGD Medium wealth category).

‘For us when you feel ill, you go to the drug shop and explain your pains to the attendant, who chooses the drugs. When things do not work out, you go to the private clinic. The clinic nurse is more technical than the drug shop attendant who when
defeated may refer you to a health center and in case the condition is worse you are taken to Hospital’ (FGD).

Another challenge identified by 8 percent of respondents in provision health service in Ngasamo is lack of profession workers. Inadequate staffing levels were compounded by a high level of absenteeism which is acceptable as it reduces access to services. About Approaching a third of all employed staff were absent from their work place, resulting to poor health service in rural area.

Other respondent said that weak partnership between clients and service providers, which is compounded by low awareness of clients’ and service providers’ rights and obligations; low public awareness of health matters such as management of pregnancy, newborn care and child care and related complications, socio-cultural barriers; gender inequalities, low women empowerment; and myths and misconceptions of various health-related issues can lead to poor provision of health service.

Quality of health care provided in the health centers was among of the challenges that emerged during the FGDs. The perceptions on the quality of care however were varied in the FGDs. The focus groups generally agreed that the quality of health care they received at the health center was poor. The women perceptions about the quality of health care was mainly focused on communication, the attitude, and efficiency of health workers, as expressed in the following comments: ‘‘... attention is poor; sometimes they don’t give you an explanation of the child’s illness’’ (FGD), ‘‘... they don’t care because they won’t even tell you the medicines they give the child and won’t give you time to ask questions’’ (FGD-2), ‘‘They don’t give medicines, just Panadol (pain killer) or a prescription when they know we are poor and we cannot afford buying medicines from shop’’ (FGD-3), ‘‘... sometimes they say we also get tired, we need to rest ...’’ (FGD-2), ‘‘... most times they don’t follow the queue and they begin treat the people they know’’ (FGD-2), ‘‘... the personnel at the clinic are selective in treating ... even if you have a very ill patient they won’t
“attend to you in good time ...” (FGD-), “They begin treat well those that live in electrified homes”

Similar observation done by Kakoko (2008) argued the distribution of health workers in the country. Despite the goal since independence to reach people living in rural areas, and despite having structured health facilities to serve villagers, most of the health workforce is concentrated in urban areas where there are hospitals. Hallebone, (2000), has argued that rural culture, patterns of illness and injury, and the shortage of practitioners in rural areas pose problems for rural populations and families.

Another practice that was noted to be unacceptable and perceived as a challenge was gender discrimination and corruption. Only half the women answered positively, whereas almost all the men, 13 out of 15, believed villagers could help curbing corruption in health sector. All the younger explained interviewees and most of those under 50 years old were also positive answers,

However 6 percent of respondent’s interviewed believed villagers could have an impact. When respondents asked to elaborate on possible ways villagers could assist in curbing corruption, they argued that through law enforcement by reporting illegal activities to the authority concerned. Villagers also believed education or access to information was a key factor, and some called for cooperation and collective action among villagers.

“If we deny paying small bribes and everyone follows the rules, there will be no more corruption, (FGD,)

One villager interviewed had easier been working with the attendant as he claimed corruption was a big problem and still exist. He gave many examples of how nurses and doctors received corruption and how villagers especially patients paid money for health service.
Corruption was obstructing development examples given were: “Those who have money can get their service those with no money have no service, (Mogan, 2005).

‘A customer is king (but) in the hospital women are mistreated because they may not have money. The men always have ‘something” (FGD).

“If the leader is corrupt, he will take all the benefits himself, without telling or sharing with the community, so the community gets no service for development”,

“Even in our village there is no development because the leaders, doctors and nurses are corrupt, it perceived corruption to be a local problem, ranking local government official, staff at public hospital, village leaders and local business people to be the most corrupt. The focus on local conditions might be because this is what they see and are affected by in their daily life. (FGD).

Another marked by 20 percent of respondents said that poor management plan and programs to upgrade workers’ skills of all the cuts in the provision of health service in village the cornerstone of skills development for human resources that were most adversely affected, judged these institutions to fall some per cent, short of staff.

The Ministry of health in Tanzania oversees not enough universities that train health professional’s institutions to train other health workers. This made significant efforts to upgrade thousands of health workers in past years, notably by investing in health training and establishing specific training centers in different zones in the country, (Lewis, 2006).

Chronically, in-service training is needed to improve skills and quality of service decreases. Staff availability of health workers must travel from their posts to attend short courses to improve performance at the working place, (FGD).

This also has been supported by Gawanas , (2005) who argued that health provision in village is being hindered by cost and poor management. However, 30 percent of the respondents mentioned budget constrains as a strong hindering factor for effective provision of health service in village, despite the facts
budgeted money and time arranged for the training is too huge, which affect the provision of health service in village, example those of professional cause shortage number of workers comparing to the tasks available in the village hospital, 14 percent of the respondents mentioned shortage of trained staff while only 7 percent mentioned low salaries tends to reduce the provision of health service in Ngasamo village.

“One respondent said she is tired to hear every year that there is budget constraints, we want to hear now the efforts being done to overcome to that challenge of budget, but it seems that the problem here is priority, and not money because other issue which cost a lot of money is done without hindered by budget, “one of the respondent added.

So this finding is in line with the observation by Mwangi (2001) who argued that in order to provide good health service in village it needs efficiency and quality of health care should provide by workers and who are competent to utilize them effective profession.

Poor implementation policy is among of challenge hindering provision of health service in Ngasamo village18 percent said in rural area, the process of adopting and implementing public policy occurs in political systems in which a variety of actors participate, even if they don’t know something which is written.

From this one may argued that the public policy analysis perspective includes the politics of health care, that is, the study of relationships of power transactions among policy actors. It recognizes that “politics affects the origins, formulation, and implementation of public policy,”(Glassman, 2008). Lewis (2006) argues that the accumulation of, and use of, power is crucial to the health policy process.

Despite this, it obvious that challenges hindering health provision are selfishness and favoritism, whereby 4.2 percent of respondents said as the result to negative effects
there is already great unavailability of drugs and medicines in public hospitals and low staff morale. A recent case is the death of a patient at Ngasamo health center after waiting for over 10 hours to be attended, because of health workers selfishness and sometimes favor their relative and friends

*During interview one patient said to be in misunderstanding with staff especially nurses because of their selfish and interests become a great stumbling block in the process of receiving health service and patients themselves to suffer due to poor service delivery in public hospitals because of this one selfish achievement of any meaningful developments in the community.*

Four of them did not say anything at all during the discussion also indicated that the respondents have a strong sense of local understanding.

### 4.4 Strategies to overcome challenges hindering effective provision of health service in Ngasamo village.

The question asked what strategies are used to overcome challenges hindering effective provision of health service in Ngasamo,

The National Health Policy (2007) aims at implementing national and international commitments and seeks to facilitate the provision of basic health services, which are proportional, equitable, quality, affordable, sustainable and gender sensitive. It goes further to suggest that public private partnership projects are to be promoted for the delivery of reliable and affordable socio-economic services.

However the National Health Policy is aimed at providing direction towards improvement and sustainability of the health status of all the people, by reducing disability, morbidity and mortality, improving nutritional status and raising life expectancy. Also national Health Policy of 2007 recognized the contribution of the private sector in health service provision. Out of this, objective to increase participation of the private sector in achieving access to health services at all levels.
proportion of the health budget to target cost effective interventions such as immunization of children under 2 years of age, Reproductive and Child Health including Family Planning and control of Malaria, HIV/AIDS and TB and Leprosy. The majority of the poor and specifically the rural people suffer from the above and other preventable conditions. The Ministry will increase resource allocation.

This implies that due to the use of Health Sector Strategic Plan of 2009-2015 (HSSP III): focuses on Partnership for delivering the Millennium Development Goals”. As a key guiding reference document for the health sector it mentions that its overall focus will be on partnership, and the sixth of the eleven specific strategies states to continue mainstreaming Public Private Partnerships at all levels and proposes three key strategies: 1) ensure conducive policy and legal environment for management of PPP; 2) ensure effective operationalisation of PPP and; 3) enhance PPP in the provision of health and social welfare services.

However, 6.6 percent of the respondents suggested that should apply the public private partnership policy (PPP) must be involved in order to solve the challenges of budget which is facing many ministries especially public hospitals, 4.4 percent of the respondents suggested that monitoring the implementation of health projects and service in village.

PPP Regulations, as the Public Private Partnership Regulations of 2011, shall apply to all projects undertaken in partnership between the public sector and the private sector. Health Sector Reform, aims at improving the health sector in provision of quality health services of which PPP is one of the strategies. Also The PPP steering committee was established to propose a regulatory policy, dictating the involvement and cooperation of providers to ensure that capacities in private institutions are used to improve the health of the people. (Mpunga, 2005).

According to the Prime Minister’s Office, PPPs are an effective alternate source of financing, management and maintenance of public sector projects, including health
services. PPPs also allow the Government to streamline responsibilities in providing social services, effectively enhancing efficiency, accountability, quality of service, (Prime Minister's Office, 2009).

This question generated different responses as following; 21 percent of the respondents suggested that health budget should be added as one of the strategy of overcoming the challenge hindering provision of health service in Ngasamo village.

However budget is the major challenge hindering effective provision of health service in village, but the Government should think the possibility of adding the budget so that many people should require good provision of health service in village, in so doing it will reduce some rumors that claim that there is nepotism, corruption and segregation in village hospital, (Ramos, 2003).

“Most of the respondents interviewed argued that ,it is true that management is not serious to overcome the factors hindering the effectiveness provision of health service in Ngasamo village, because those hindering factor seems to be common every year, without coming with solutions on how to solve the matter like finding permanent donors. Additional efforts are therefore needed to ensure that these interventions reach the poor in rural areas and achieve coverage levels that can lead to significant reduction in child mortality. These interventions enable people to gain access to health care in rural areas like Malili and malangale. The aim isto focus on improving provision of health services, information flow between health care providers and users and strengthening of existing theseveral programmes by raising awareness in thecommunity, health issues to increase demand for health services, exploration of appropriate incorporation of other health sectors into the formal sector, and promoting community members involvement in health issues at household level,( FGD.).

The observation done by Jackson (1998) argued that ministry of health should think to increase the budget of procuring enough facilities for hospital use.
Despite the fact that, budget is the major factor hindering effective provision of health service in Ngasamo village, but the Government should think the possibility of adding the budget so that many people should require good provision of health service in village, in so doing it will reduce some rumors that claim that there is nepotism in village hospital, (FGD)

Also 16 percent of respondents recommended that staff should be available at the health center at village in order to improve health services. Management is required to increase number of health workers in rural in order facilitate and pulled in different ways and to attend seminars, to give high salaries health workers per population. Where nursing staff had been employed and were available on site in primary facilities, a surprising amount of time was non-productive, with over half the nurses being unproductive.

Lack of staff in rural settings as one of challenges in provision of health service as resulted into poor health service delivery which given by untrained health workers. it is therefore suggested that possible incentive schemes should be set out in order to attract trained people to work in rural areas. "Pull incentive packages" could involve provision of hardship allowances, housing, improved management, local recruitment or clear career development plan; "push incentives" could involve implementation of coercive measures such as bonding, in which health workers are obliged to serve in rural areas for a number of years upon completion of internship. well such (FGD Melina).

It should be noted that provision of health service in village needs regularly supervision in order to improve and monitor the quality of services given to the patients. (Allan, 2002).

It observed that supervision has been proposed to improve the efficiency of supervision visits as part of village Health Intervention programme and this is worth taking forward. To improve supervision is likely to require timely, disbursement of
funds, sufficient staff, prior notification of visits, appropriate training for supervision and improved supervision village level staff,(FGD, Moses).

Another strategy in provision of health service in Ngasamo village is to improve infrastructure especially transport. About 13 percent of respondents mentioned that improve transport in village and upgrading workers in health sectors. One respondent interviewed said long distance to health facilities has been identified as a challenge to health care in rural area community members, he said that villagers who live closer to the health facility are more likely to utilize the health services than villagers who live far away that health centers. Approaches that can alleviate the distance problems include strengthening of the existing outreach programmes and strengthening and extending services of community health workers to ensure targeted delivery of services closer to the households.

Interventions also need to address the demand-side barriers to health care in addition to the supply-side barriers. This includes the need to increase the awareness and understanding of different illnesses and the available preventive and curative services among community members. Issues of laziness, ignorance, and not taking patient hospital can be targeted by such efforts. Communication channels to disseminate health-related formation, education, and communication need to be strengthened to reach target community members. Various communication channels like dances, public lectures, and role plays have been shown to be effective in rural settings,(FGD).

In order for a health care delivery program to be successful, these transport barriers must be addressed. This can be accomplished by the provision of transportation via rural outreaches, providing subsidized or free medical care, and utilizing community health workers to educate local people about treatment options,(Makus,2001). Another strategy may be added as an improvement to have effective implementation of health policy in rural areas which would show clear success to provision of health
service. 15 percent of the respondents mentioned that good implementation of health policy in village Help to deal and to overcome the problem.

26 percent of respondents suggested, ministry of health should have clear implement of village health policy despite of the fact that, the presence of health policy it needs good implementation.

It was suggested that health workers should avoid corruptions, segregation and politics when provide health services to clients. Every individual should be responsible to his/her work as they are there to serve people as per job descriptions. 

Health workers must increase external accountability through provision of health service to public hospital, (FGD).

It was suggested that to increase transparency in health sector can avoid corruption. Profession health workers must work closely with community even in the process of disclosing information on how decisions are made, as well as measures of performance, we can improve public, reinforce accountability and inform citizen choice. In addition, transparency helps to document and disseminate information, (Molina, 2007).

It argued that Health provision system should ensure that public health interventions are linked to those who need them but more effort is needed to integrate health packages into village and district level budgets and planning, Patient can be saved by implementing appropriate policies, improving staffing levels and supervision in health facilities and providing an enabling environment for community-level care.

There an immediate opportunity for Tanzania to implement the recommendations within the Road Map/One Plan to improve health provision from the highest level in both public and private health facilities and to influence the care patient receive at any health Centre,(Bravement 2008).

Furthermore one Doctor interviewed and said that Tele-health and telemedicine as among of the strategies to solve the problem of health provision in village, has the potential to solve a number of problems of distance, but its success in the longer term will be a function of the degree to which it meets the real health needs of consumers and health practitioners.
Telehealth can substantially help to reduce the isolation for families. In addition, there is also a need to incorporate a human element into health care, together with technological developments to meet a range of rural and remote socio-cultural and psychological needs, (FGD,Masaba).

Other doctors and nurses explained that the dissemination of telemedicine will empower consumers through Internet health resources, self-care tools and an improved relationship with healthcare providers. While limitations to their use do exist, advanced technologies such as Information Technology (IT), the Internet, and the use of telemedicine, tele-health, and e-health can provide some solutions to the problems associated with inadequate medical and health service provision in rural and remote areas. Service providers and recipients of health care services should be involved in the initial stages of development and implementation of these technologies.

Introduction and implementation of Tele-health is that consumers and providers of services must be involved in the decision making and implementation of such services. In the past, too many programs have been implemented by government agencies, software companies, and technologists without adequate 'on the ground' consultation with service users. In addition, Telehealth experts from other disciplines such as sociology, law, politics, economics, and psychology need to be involved to align decisions that are made purely within a technologist paradigm,(Donald, 2009).

Technology has the potential to provide a partial solution to the problems of access to health services in rural and remote regions. The application of information technology to the health sector is referred to as telemedicine, which is a 'subset of health telematics,(Liaw,2000).

Other responses from the respondents in this research question were as follows, about 78 percent of the respondents said that there are strategies to overcoming the challenges of provision of health service in Ngasamo village particularly in public sector, while 20 percent of the respondents said that there are no strategies and
02 percent of respondents said they don’t know. Although the findings indicate that provision of health service has strategies to overcome the challenges hindering the effective provision of health service in Ngasamo village, there some respondents are totally refusing that there is no any strategies of dealing with that challenges, this imply that ministry of health management should add.
CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction
This chapter presents summary of findings in relation to research problem and objectives, conclusion and recommendations that the researcher thinks are important to be considered in order to improve the provision of health service in rural areas.

5.2 Summary
The research was done research about the challenges facing provision of health service in Ngasamo village. The methods/ instruments used in gathering data were questionnaires and documentary review. The respondents were from Simiyo Region. The perception of respondents about provision of health service in Ngasamo village was positive despite the fact that health service is very costing. According to the findings provision of health service in village seems to be important for the survival of any community level, thus why about 96 percent in this study shown positive comments of the service given.

The study proves that provision of health service in village increase efficiency, quality and standard of people who are living in community. respondents indicated from the findings whereby 60 percent of responses from the study, identify the challenges. Although there are other challenges of provision of health service like improvement of professional workers skills, increase performance of workers as well as increase salaries and motivation, the findings show that ministry of health some time does not consider the procedure of providing health service in rural areas for example in Ngasamo village.

87 percent of responses admitted that the ministry of health has consider by identify first priority in the provision of health service in village/ rural areas.
The study has identified budget constraints and lack of implementation policy, as the major challenges for the provision of health service in village. It seems that the ministry of health fails to send health professionals in village hospitals because of shortage budget, although there is no objection that health service is inevitable in rural areas. Despite the facts that provision of health service costs a lot of money and sometimes may interrupt the community production in the procedure of serving the community it need to find other sources in order to overcome that sanction.

Study revealed that provision of health service in village has cost because of difficult faces in rural area, hence it suggested budget should be added, plus establishing implementation policy as among of the strategies to overcome challenges hindering provision of health service. It also suggested the introduction of public private partnership (PPP) in order to solve the challenges of budget facing many ministries especially public sector, because government cannot afford such cost alone without assistant from other development stakeholders.

Also the issue of lacking of the competent management plan’s officers who knows the important of provision of health service has been mentioned in the study as another hindering challenge

5.3 Conclusion

Tanzania has come a long way in provision of health services in rural accessible to the population. But a lot more needs to be done, and only Tanzania Government can make it happen. Of course, they will need the collaboration of the private and NGO sectors and the international community. Nevertheless, until they assume the leadership in the expansion and management of provision of health service programs, we should not expect significant results. How Tanzania government respond to this challenge will determine the path that the country will follow in its development endeavor.

The relatively low level of poor provision of health service in rural areas, in rural settings is a problem for a vast majority of health initiatives in Tanzania. Why is this
so? The critical challenges behind the generally low levels of provision of health service in rural Tanzania include:

- lower population density
- poorer infrastructure, fewer services
- greater distances to travel to reach those services
- generally lower levels of education, higher levels of poverty
- social and economic organization dependent on the local pattern of agricultural production, thus quite different from that in towns
- cultural norms constraining the acceptability of modern health service provision methods. (Arguably, this is a grossly simplified account. In reality, the circumstances rural communities live in can be very diverse, making generalization difficult.)
- budget deficit,
- lack of implementation of policy in village hospitals,
- lack of competent health providers, and abusive language used by health providers to patients
- high costing,
- lack of seriousness and commitment to workers
- corruption persists in the health sector seems to be the big challenge in the provision of health service.

Taken together, population growth, too few health workers and their poor morale, lack of equipment and medical supplies, and increasing health burdens from chronic and emerging diseases have overwhelmed the capacity of the health system. The overall performance of health service delivery is unsatisfactory at all levels, especially in the public sector. Commitment by the government and other stakeholders of adequate financial and human resources, together with their efficient and effective utilization, will go a long way to improving Tanzania's health system and the health of its population.

The signs of change are building up, global in scope, extending across all sectors and levels. Many of these changes are directly linked to health, while others have powerful potential effects on both health and health provision. Provision of health service needs to be adapted to varying circumstances at local and national levels.
Any community that establishes a solid basis for both provides for the needs of its most vulnerable and needy populations and, at the same time, empowers its most neglected resource - women.

5.4 Recommendations

Basing on the findings of this study, the researcher makes various recommendations aiming at improving performance and provision of health services in the public hospitals, as follows;

5.4.1 Recommendation to the workers

The health professionals/workers should develop positive perceptions and attitudes towards provision of health service in rural areas/villages since the study show that there are some health workers about 4 percent of the total have negative perceptions towards provision of health service in rural areas, despite its important. They should stop to believe that health service consumes the ministry more funds unnecessary, because for the ministry to survive longer it should invest in health service.

5.4.2 Recommendations to the Ministry of Health and Social Welfare

The ministry should be seriously invest in health sector especially in remote areas, despite the facts that it is costing by preparing enough budget, preparing sustainable implementation of health policy, employing competent and professionals workers, and provide a support to management plan. The issue of segregation, politics and corruption in health sector should be avoided as it hinders provision and implementation of the health service programs.

5.4.3 Recommendations to the Government

Here, government should make sure it increases its budget especially in village hospitals to its institutions and supervise closely its utilization, so that should not send that budget into other project. Government should make sure that health sectors have implement sustainable health policy that can be guide the beneficiaries in the process of receiving health service. Also government should make sure that qualified
and competent health workers are employed to fill various positions in public hospitals, and last government should make sure that it works hand to hand with private sector in order to solve the problem of budget constraints through allowing the public private partnership (PPP).

5.5 Areas for Further Research

This research is not representative of the whole health sector in Tanzania. Any other public sector or private sector could produce the same or different results since the sample covered in this study was limited only to the Ngasamo village hospital which is under ministry of health and social welfare.

Therefore it is recommended for more reliable generalization of findings, a similar study to be carried out on large scale involving comparison between public and private sectors on the same issue. This will bring out the wide knowledge about the problem and finally advocate for the growth, and development for the entire nation.
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APPENDICES

SELF-ADMINISTERED QUESTIONNAIRE FOR THE CHALLENGES FACING PROVISION OF HEALTH SERVICE AT NGASAMO VILLAGE IN BUSEGA DISTRICT

My name is Leah M, a student at Mzumbe University pursuing Master Degree in Public Administration. I am doing a study on the challenges facing provision of health service at Ngasamo village in Busega District. Your response to a few questions below will make this study a success. Your information will be treated confidential and will be used for research purpose only.

Kindly fill in the provided empty space. Put a tick in front of the answer you have chosen. In places where you have been provided with options, please pick one and tick. If requested to comment or explain, please assist by doing so.

Section A:

Personal particulars:

Please answer the following questions.

1. Age status
   18yrs-30yrs ( )
   31yrs-50yrs ( )
   51yrs-60yrs ( )

2. Education level,
   Primary school ( )
   Secondary school ( )
   Diploma ( )
   First degree ( )
   Masters’ Degree ( )

3. Sex, status
   Male ( )
   Female ( )

4. What is your position in the community?

....................................................................................................................................................
Section B:

1. What are the types of health services are being provided in village hospital? (Mention at least five)

   (1) ..............................................................................................
   (2) ..............................................................................................
   (3) ..............................................................................................
   (4) ..............................................................................................
   (5) ..............................................................................................

(2) Whom do they target?

   (1) youth (  )
   (2) All Citizens (  )
   (3) Both youth and All Citizens

3. How do you rank level of provision of health services in village

   (1) Very high (  )
   (2) High (  )
   (3) Moderate

4. What is the response of the users/patients?

   (1) Positive (  )
   (2) Often positive (  )
   (3) Negative (  )
   (4) Both positive and negative. (  )

5. Are you aware with health services are being offered in village hospitals, please mention

   (1) ..............................................................................................
   (2) ..............................................................................................
   (3) ..............................................................................................
   (4) ..............................................................................................

6. What initiatives have been taken by the ministry of health in general in promoting health services provision in villages? (Mention at least 3)
7. What are the problems / challenges being faced in the ministry of health in offering health services in villages? (Mention at least 4)
   (1)........................................................................
   (2)........................................................................
   (3)........................................................................
   (4)........................................................................

8. In your opinion what do you think could be a major problem of provision of health service in villages.................................................................................................................................
.................................................................................................................................

9. What induce doctors and nurses to perform better in the provision of health services in villages.................................................................................................................................
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................

10. Mention the type of health service you received within in village hospitals?
   (1).................................................................
   (2).................................................................
   (3).................................................................
   (4).................................................................

11. What are the impact of poor provision of health services in village
   (1).................................................................
   (2).................................................................
   (3).................................................................
   (4).................................................................
   (5).................................................................
12. Mention any some tradition and culture of some tribes which contributes to receive poor health service in village?
   (1) .................................................. 
   (2) .................................................. 
   (3) .................................................. 
   (4) .................................................. 
   (5) ..................................................

13. What are the causes of poor provision of health service in village
   (1) .................................................................
   (2) .................................................................
   (3) .................................................................
   (4) .................................................................

14. What are other challenges of provision of health services have you observed in the villages?
   (1) .................................................................. 
   (2) .................................................................. 
   (3) ..................................................................
   ...

15. You are a member of community, what are the challenges that has occurred in the process of receiving health services?
   .....................................................................................
   .....................................................................................
   .....................................................................................

16. You are the community member, mention the important to be provided health services within the village
   (1) .........................................................
   (2) .........................................................
   (3) .........................................................
   (4) .........................................................

17. Explain the factors which hinder provision of health services in village?
18. Which factor/ hinder the provision of health services programs in the public sector from the following?

(1) Budget constraints
(   )

(2) Community are not aware
(   )

(3) Segregation
(   )

(4) Bad policy
(   )

19. Mention that poor technology in the process of provision of health services in the village as the result to poverty.

(1)……………………………………….
(2)……………………………………….
(3)……………………………………….
(4)……………………………………….
(5)……………………………………….

20. What are some of the strategies used by the public hospitals to overcome factors hindering provision health services in villages?

(1)……………………………………………………………………………………….
...
(2)……………………………………………………………………………………….
...
(3)……………………………………………………………………………………….
...

21. Do you know any policy concerning the issue of provision of health service provided in village? please mention ………………………………………………………
…………………………………………………………
22. What should be done by the community in relation to the provision of health services, in order to increase efficiency in the village hospitals?

The following Interview guide provides a list of questions asked during the course of all interviews. The questions list is thematically arranged, and do not reflect the sequence of the questions asked during each interview. Additional questions were often added according to the situation at hand.

(1) Do you know anything about provision of health service in villages?
(2) Are there any health service provided in your village?
   (3) Who are benefits from provision of health service provided in village?
   (4) Is there any initiative taken by ministry of health to promote health service in village?
   (5) What do you think the ministry of health can promote health services in villages?
   (6) Do you know any benefit of provision of health service in villages?
   (7) What are the challenges of provision of health service in villages?
   (8) Do you think stakeholders are aware of provision of health service in villages?
   (9) Are you satisfied with health service provision in villages?
   (10) What should be done to improve provision of health service in villages?
   (11) Can you suggest anything which can add value to provision of health service?

The following question focus group discussion guide provides a list of questions asked during the course of discussing the topic. The questions list is thematically arranged, and do not reflect the sequence of the questions asked during each discussion. Additional questions were often added according to the situation at hand.
1. Please tell me more about provision of health service in village?
2. Please give me an example of health services provided in the village?
3. Please help me understand meaning of health service?
4. How significant is the problem?
5. What causes the problem?”
6. Could you give me an estimate of the % of community members who have access health services in the village?
7. What additional services or program would help people address these Problems?
8. What are some of the barriers to implementing health service within the village? How about to accessing health services?
9. Now that you've identified barriers to implementing health services and accessing health services, do you have any suggestions to overcome these barriers?
10. Can you tell me about any of your personal experiences related to overcoming these barriers? 11. Are there any “promising practices” you know to address these barriers?
12. Is there anything else you would like to add to this discussion before we end?
13. How to improve the implementation of health service and provision to victim in (village).
14. Identify strengths and gaps in provision of health services to hospital in (village).
15. Identify strengths and gaps in state laws and agency policies that guide.