ROLE AND INFLUENCE OF LOCAL GOVERNMENT AUTHORITIES IN MANAGEMENT OF DECENTRALISED HEALTH CARE SERVICES FOR PREGNANT WOMEN:

A CASE STUDY OF DODOMA CITY COUNCIL
ROLE AND INFLUENCE OF LOCAL GOVERNMENT AUTHORITIES IN MANAGEMENT OF DECENTRALISED HEALTH CARE SERVICES FOR PREGNANT WOMEN:

A CASE STUDY OF DODOMA CITY COUNCIL

By

Agnesta Augustino

A Dissertation Submitted in Partial/Fulfillment of the Requirements for Award of Degree of Master of Research and Public Policy of Mzumbe University.

2019
CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a research report titled "Role and Influence of Local Government Authorities in Management of Decentralised Health Care Services: The Case of Dodoma City Council", in Partial/Fulfillment of the Requirements for Award of Degree of Master of Research and Public Policy of Mzumbe University.

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DEAN, SOPAM
DECLARATION AND COPYRIGHT

I, Augustino Agnesta, do hereby declare that this is my original work and it has not been submitted for a similar or any other degree in other University.

Signature..........................................

Date..................................................

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Acknowledgment

This thesis has become a reality with the kind support of different persons. I would like to extend my sincere gratitude to all of them.

Foremost, I would like to thank our almighty God for the wisdom bestowed upon me, the strength, peace of my mind and good health that enabled successful completion of this thesis.

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Lastly, I wish to express my sincere thanks to my mother for all the occasional support and encouragement.
DEDICATION

This dissertation is dedicated to my loving brothers Stanley, Gasper and Alex. I have dedicated this work to you and hope it will inspire you to work and achieve success in your educational endeavors and careers, so that you can brighten your future and make a significant contribution to your growing nation.
# ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>BANC</td>
<td>Basic Antenatal Care</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Committee</td>
</tr>
<tr>
<td>CHMT</td>
<td>Council Health Management Team</td>
</tr>
<tr>
<td>DISP</td>
<td>Dispensary</td>
</tr>
<tr>
<td>FHS</td>
<td>Free Healthcare Service</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>LGAs</td>
<td>Local Government Authorities</td>
</tr>
<tr>
<td>MoHCDGEC</td>
<td>Ministry of Health, Community Development, Gender, Elderly and Children</td>
</tr>
<tr>
<td>PORALG</td>
<td>Presidents Office-Regional Administration and Local Government</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Science</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
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ABSTRACT

The study assessed the role and influence of Local Government Authorities (LGAs) in managing the decentralised health care services. Specifically, the study aimed to: assess the LGA health care services roles, structures and procedures for pregnant women in Dodoma City; examine the quality of health care services provided to pregnant women; assess the roles and influence of Dodoma City Council on management and provision of health care services to pregnant women. The study used case study design. Purposive and convenient sampling techniques were used to get a sample size of 120 respondents. Data were collected by semi-structured interview, questionnaire and the documentary review methods. Data were analysed by content analysis and descriptive statistical methods.

The first objective found that the LGA administrative roles are coordination, supervision and monitoring health service delivery between the city council and health centers. The Council Health Management Team was the specific structure from the local government authority. The CHMT approves budget, identifies service delivery gaps, prepares and presents weekly report, identifies shortages observed on health facilities and makes follow-ups on medical officers. Pregnant women adhered to procedures like consulting doctors, take pregnancy test, and seek for the clinical card. The second objective revealed that the quality of service was perceived to be very impressive by 70%, due to quality treatment by doctors and nurses and the presence of prescribed medicines. In the third objective, the study discovered that the Dodoma LGA has a moderate influence by 63% in managing the provision of free health care services to pregnant women. It provided training to pregnant women, inform about reproductive health, campaign against HIV, TB and other diseases through media. In conclusion the LGA plays its roles in administering the provision of free healthcare service for pregnant women. The study recommends for the programme to continue with several improvements on health delivery.
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CHAPTER ONE
PROBLEM SETTING

1.1 Introduction

It is evident that when a woman plays her biological role of becoming pregnant and gives birth to a child, the society is obliged to fulfill her basic human rights of taking care of her and the child that is born from the mother (URT, 2011). However, studies found that about 536,000 women in the world die from pregnancy and child-birth related conditions (ESRF, 2011). In Tanzania, the estimated number of maternal deaths was about 13,000, of which majority died from poor health attendance (Kasina, 2016). Arguing at this point the government of Tanzania was urged to undertake different measures to reduce to the lowest possible level the risk of maternal deaths by guaranteeing special health provisions for women in gestation period.

Obviously, the LGAs have a central role to play in ensuring effective provision of special health services to pregnant women. As indicated by different scholars, in Tanzania, the LGAs have mandates to coordinate and implement sector policies in the process of service delivery (ESRF, 2011; Borghi et al., 2015). To undertake their implementation and coordination role effectively, the LGAs needed to be influential. But this depended on how the existing decentralisation policy gave opportunities for these authorities to perform.

The study describes the background of the problem, statement of the problem, research objectives, research questions, the significance and scope of the study. Finally the organisation of the dissertation is presented.

1.2 Background of the Study

The developing countries like other nations were urged by the international organisations like the World Bank and International Monetary Fund to decentralise their systems of public administration (Cheema and Rondielli, 2007). The basic
assumption was that decentralisation in public administration has profound contribution on the effective provision of social amenities, involve community members to take part in decision making on issue of their concern and strengthen the democratic governance whereby citizens are at the center of their government focus. The proximity interaction created by the decentralised governance system was believed to untie the blocks which undermine the ability of leaders in the lower government systems in administering the delivery of services to people around them. It therefore followed that, decentralisation system played a mediating role whereby the government becomes near to its people and responds to the needs and demands preferred by the people in the given context. In turn citizens were empowered to oversee and question on the decisions and deeds of the government hence fostering transparency and accountability. At best decentralisation was expected to uphold democracy in the grassroots; however, literature portrayed a mixed image of the norm. Scholars supported the view that decentralisation of government serves to improve policy implementation outcomes in terms of improved service delivery (Fleurke & Hulst, 2006; Riesman, 2002; Azfar et al., 2001).

Others portrayed the inverse of reality by showing that decentralisation culminated to a sense of regionalism, poor administration of resources and deters the ability of central government to influence policy determinations (Asaju, 2010). In fact the conceptualisation of decentralised government was embedded in the formation of local government system. The local government in essence is an output of the decentralisation process in many countries in Africa and elsewhere. In other words, to understand the process of decentralisation of governance system in any nation, it was indispensable to learn the local government system and its history (Bardhan and Mookherjee, 2003). In Africa, governments adopted decentralisation policies as to uphold the governance system and enhance citizen participation in government affairs. It was in this regard that nations assumed decentralisation procedures would serve as means to which the government and the people meet to make decisions and undertake actions in more participatory approaches.
History tells that, the decentralisation systems in Tanzania underwent different reforms for the need to respond to the nature of mandates or authority of the local government given by the central government (Frumence et al., 2013). In the need to implement the local government reforms since its independence, the government of Tanzania undertook different initiatives among them were to impact on the decentralisation policy and reforms. Learning from the local governance system of the colonial rule, the government after independence decided to change the nature of local government. There was need to enact the decentralisation of local administration (Interim Provision) Act in 1972 (Mnyasenga, 2017; Crook, 2003). Under this Act, the government ruled out the local government authority systems of governance and all powers were centralised to the government. However, the authority of local government replaced by Regional and District Development Councils.

Following the Structural Adjustment Programmes, the government decided to reintroduce the LGAs system in 1984. To make it more strong and valid, the legal and policy frameworks for local government systems were re-instituted. In accordance with the constitutional and legal status, in 1984 the Local Government authorities expanded to district councils in rural areas and municipal and city for urban settings. Councils were endorsed with powers to conduct elections of councilors, enact by-laws, monitor revenue collections and determine the local budgets and plans (Tidemand et al., 2010).

Other important reforms were undertaken to empower the LGAs particularly on four major aspects: the political decentralisation, financial decentralisation, administrative decentralisation, and changed central local Relations (REPOA, 2008). These reforms among others are the Local government Reform agenda of 1996 followed by the Policy paper on Decentralisation by Devolution (Lameck, 2017). These reforms gave birth to Decentralisation by devolution policy in 1999. The D-by-D policy was very important instrument in strengthening the powers and mandates of the local government authorities particularly in the delivery of services and ultimately in view of alleviating poverty in the country. In reality, the core
objectives of the Local government Reform Programme were to improve the quality of access to public service provided by the local government. In other words, the rationale for the reestablishment of Local Government Authority was to decentralise the governance system, simplify provision and monitoring of public services, to enhance people participation in decision making and implementation, undertake local elections and empower councilors on running the local affairs at the levels of districts, municipality and cities.

Congruent to the LGAs reforms, different reforms were undertaken in the health sector to achieve the intended goals of improving health service delivery in user-free mode for the special groups. Scholars argue that the health sector reforms were successive to the reforms of the local government authority as both geared at improving service delivery in particular health services. It followed that, the Reforms in health sector are interlinked with the local government Reform Programme (LGRP) as both aimed to decentralise personnel, planning, financial and decision making of public service delivery to the districts and municipal levels (URT, 2001).

Among others the government of Tanzania has demonstrated strong commitment to provide free health services to some special groups including pregnant and maternal women. These groups are said to be vulnerable hence, the need for special attention on health service delivery. Under normal condition pregnancy is not a disease and requires very little external interventions in its development. In Tanzania, the experience shows that pregnant women are vulnerable to anemia due to increased demand for iron and folic acid (TDHS (2005). They also need to have received at least one dose of Tetanus Toxoid (TT) in their gestation period.

Some scholars found that the decentralisation process in different countries like Argentina and Bolivia demonstrated positive impacts on the delivery of health and education services, improved citizens satisfaction and facilitated easy access to such services by marginalised and vulnerable groups (Habibi et al., 2001; Eskel and Filmer, 2002; Tidemand and Msami, 2010). In contrary, other studies have reported that the decentralisation processes result to weak governance of services delivered in
the sub countries due to embezzlement of funds and low quality of leaders and administrators (Gabral, 2011; Jutting, 2004). The contradictory dispositions call for the need to study on the decentralisation process of and the influence of the local government in administration of health service delivery to pregnant women in Tanzania.

1.3 Statement of the problem

In Tanzania primary and health care services related to pregnant women are supposed to be provided free of charge under the supervision of the local government Authorities (Bardhan and Mookherjee, 2003). The decentralisation process in health sector gave power to the LGAs to administer free health care services to pregnant women in Tanzania. Nindi (2015) argued that, the fact does not seem to be a reality in many parts of the developing countries such as Tanzania. Literatures suggested that the formal administration systems have not been favorable enough to actualise the professed goals in decentralisation of local government (Mnyasenga, 2017; Lameck, 2017). In turn the LGAs are reported to have failed to effectively administer numerous of delivered services to its citizens (Mnyasenga, 2017; Gabral, 2011; Jutting, 2004). There seem to be contradiction between the theoretical affirmations of the usefulness and the practice. With regard to the observed discrepancies the study was needed to explore the influence of LGAs in co-ordinating the provision of free-user health services to pregnant women. It is on this juncture that the study sought to uncover the administrative roles and influences of the LGAs in Dodoma city that influence delivery of free health services to pregnant women.

1.4 General objective

To assess the roles and influence of Local Government Authorities in management of decentralised free health service to pregnant women in Tanzania.
1.4.1 Specific objectives

i. To assess the roles, structures and procedures for management and provision of health care services to pregnant women in Dodoma City

ii. To examine the quality of health care services provided to pregnant women in Dodoma city;

iii. To assess roles and influence of Dodoma City Council on management/administration of health care services to pregnant women in the area.

1.4.2 Research questions

i. How effective are the roles, structures and procedures for management and provision of the health care services to pregnant women in Dodoma City?

ii. Of what quality are the health care services delivered to pregnant women in public health centers in Dodoma City?

iii. What are the roles and influence of the Dodoma City Council in management of health care services delivered to pregnant women?

1.5 Significance of the study

The issue of health care provision to pregnant women is very important for reduction of maternal mortality rate and ensures safe child birth. This study is important because it provides some insights on the status of the health care services to pregnant women in Dodoma City and how can such services be improved. In this way the study contributes knowledge that the policy makers can utilise to enhance the existing efforts towards maternal mortalities. The findings from this study can also shade a light to health care providers in the public and private sectors in Dodoma City and elsewhere in the country on how they can improve the services and contribute to government efforts to reduce maternal mortality rates. In addition, the results of the study would inform the interested actors about health care services to
pregnant women and enhance their understanding and advocacy on the importance of promoting access to health care services for pregnant women. Finally, the study is of great importance to researchers and scholars interested in health care services especially to pregnant women as it provides first-hand information from the women who use the services and service providers. The practical information from this study helps to improve the existing knowledge on health care services to pregnant women.

1.6 The scope of the study

The study was conducted in Dodoma City Council. It focused on assessing the health care services provided to pregnant women in the city through the public Health care centers and Hospitals and role of Dodoma City authority in management of such services. The study assessed the health care services provided within the period from 2008 to present.

1.7 Limitations of the study

The study faced a number of obstacles. The first of these obstacles is deficit of literature resources to inform the study objectives in particular research works from within Tanzania. Another limitation was lack of willingness of respondents to provide sound and useful data about the practice in the health centers and hospital due to fear or worries of either sustaining their positions or being misunderstood. In response to this limitation, the study consulted various useful documents from outside Tanzania to be informed of the existing trends in health care services provision to pregnant women in the city in addition to interview data. Moreover, the researcher sought consent from participants before any interview session and provided assurance that their information would be used confidentially and purely for academic purposes.
1.8 Organisation of the dissertation

The report contains six chapters. Chapter one introduces the background of the study, statement of the problem, study objectives, research questions, significance, scope and limitation of the study. Chapter two provides a detailed analysis of literature review. It involves the presentation of theoretical and empirical literatures reviews as well as the conceptual framework. Chapter three elaborates the methodological aspects used in the conduct of the study. The chapter consists of the research approach, research design, area of the study, sampling techniques and sample size, the methods of data collection, analysis procedures and ethical considerations. Chapter four is composed of the presented results and findings basing on the specific objectives. Chapter five discusses the findings of the research study.

Chapter six presets the summary of the study, conclusion, implication and recommendations. Other aspects include the suggested areas for further research. Together with the presented chapters, the report has the reference section and list of appendices for research instruments.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter presents the works done by former scholars pertaining to the issue of role and influence of LGAs in provision of free health care services to pregnant women. The reviews under concern are those to do with the theoretical framework, empirical reviews and conceptual framework. The aim behind this literature review is to evoke what and how the past studies on decentralisation of governments and health care service delivery inform the current study, and ultimately to bring about the knowledge gap that the prospective study has to fill in through research.

2.1.1 Concept of Decentralisation

The decentralisation is an idea that is not always easy to underpin without being categorized into specific field. In this study, the understanding of the word decentralisation is coined under the perspective of the government and governance. It is in this regard that, the concept is defined by the World Health Organisation (2008) as the transfer of authority and responsibility for governance and public service delivery from the central government to lower structures of governance through different forms such as deconcentration, delegation, devolution, privatization and/or community participation. In practice the act of decentralising the government powers and authorities is thought to be instrumental approach towards ensuring the exercise of democracy, promotion of people participation, encouraging transparency and accountability of the public officials to its nearest people in the grassroots (Marijani, 2017). In this paper the decentralisation is conceived the transfer of powers and authorities by devolution from the central government of Tanzania to local government Authority.
2.1.2 The Decentralisation Theory

The theory was founded by Wallece Eugene Oates 1972. The central claim of the theory is that each public service has to be provided by the jurisdiction which has control over the minimum geographical area that could internalise the costs and benefits of the provided service. Other scholars attribute the decentralisation theory with the practice of lowering administrative powers and authority to the lowest level of governance. Decentralisation system says Fleurke and Hulst (2006) provides suitable environment for citizens to participate and monitor service delivery, thereby being able to have freedom to plan, contribute or supervise the delivered service within their reach of their context. The decentralisation system is expected to enhance equity for citizens from the grassroots groups of the society including special groups like children, expectant mothers, elders and others. Shah (2006) further added that in occasion where the public good has to be provided by the central or local government to the population of its people, for the provision to reach the intended part of the population it is indispensable to involve the nearest authority under the given defined geographical jurisdiction. The local government therefore is presupposed to ensure efficient output than if the central government would play the role of providing service to people. The simple reason is that, the central government will focus on assuring uniform level provisions of the service with less concern of the exceptional or specific groups of people, whereas for the local government it is easy to identify and priorities service delivery to the most needy and vulnerable groups of people including pregnant women.

Proponents of decentralisation theory argue that decentralisation imply government sense of efficiency orientedness, democracy and participation of people in decision making, hence reduces the cost of service provision, simplify unnecessary bureaucratic formalities and encourages inter regional competitions on final rendement. Regarding the local government authority and decentralisation, the theory assume that local government leaders understand better the concern of the people in their jurisdictions than it does the central government. It follows that, the issue of financial and political decentralisation will facilitate collaborative decision
making, enhance efficient service delivery and responsiveness to the demands of the community around (Mnyasenga, 2017). In addition, the decentralisation is sought to devolve the powers of the central government and minimize the implementation complications of the central government policies and programmes thereby translating the major goals of the policy and laws into eligible and practical situations.

The decentralisation theory assumes that good governance can be attained in local government through proper policy options and community participation. The international agencies like the World Bank and International Development Bank have been promoting decentralisation as among the aspects of good governance (Justin, 2004; Rondinelli and Cheema, 1983). The decentralisation is said to improve development through citizen’s participation in the government decision and implementation, raising the accountability and responsiveness level of local government leaders (Crook and Manor, 2000). The provision of public services would reflect the preference of the local community and adapt to the context basing on the reality on the ground. It is therefore important for the central government to discharge its powers and authority to the local government for it to have powers and ability to implement its function as postulated in by the law.

2.1.2.1 Decentralisation Model of Service Delivery

This theoretical model of decentralisation functions at the level of local government offices in the course of providing services to the public. According to Padreep (2011) the decentralisation service delivery model is based on the subsidiary principle of governance whereby, the services and products to be delivered are devolved to the lowest level of the government. In addition, local bodies are subject to delivery of the services as per the guidelines provided by the national and local decision makers. The local government Authorities perceived to be the nearest custodians to the local population are thus they are well positioned to match with the supply of a given service to citizen’s needs accountability (Eskel, 2001). The emphasis of the model is that delivery of the services requires strong interrelationship of accountability among actors in the service delivery chain. In case
of the private sector the chain is strictly managed by the need to meet the competition rate where the services providers are directly accountable to the clients.

In the public sector, the situation is different since the clients are not directly holding the national government accountable but only through the nearest decision makers and implementers. The national decision makers/politicians are supposed to allocate resources to towards service provides then, the policy makers hold accountable the service providers at the lower government level. The chain is referred to as the long rout of accountability (Keefer and Khemani 2005). In case of the health service delivery, the public spending of the service depends on the extent to which citizens; the service recipients can hold the politicians and the service providers accountable. In some cases, though politicians can be held accountable, the problem still remains on the responsiveness of the service providers and the local government decision makers to the needs of the service users. This is the concern of the study, since the local authority is much easier to be faced by the citizens. The devolving responsibility for service delivery to the lower levels of government implies that politicians accountable to the service are found within the local area; hence supervision can be improved as it is expressed in Figure 2.1.

**Figure 2.1: Decentralisation and service delivery**

![Diagram of decentralisation and service delivery](image)

**Source:** Model adopted and edited from Ahmad *et al.* (2005)
From Figure 2.1, the direction of the arrows indicates the flow of accountability. The decentralisation process is expected to place political and government leaders to be more accountable to citizens through service delivery. The devolution of powers is expected to be handled simultaneously with the decentralisation as to improve the quality and availability of resources but also the management capacity of the local government authorities as to be able to make decisions, plan and regulation expenditures between the central government and the service providers for the benefits of the recipients.

2.2 Concept of Local Government Authorities (LGAs)

The local government authority denotes to aspects which are being the government and being an institution (Benz, 1987). The term local government is conceived to be an institution which is large enough to exercise some functions including provision of services like education, health, disaster management, water supply and other administrative functions. However, being posited as local government authority, it implies that it is not sovereign, since its powers and authorities are derived from the central government which is all autonomous and sovereign body of governance.

The national constitution of the United Republic of Tanzania recognize the local government as autonomous bodies whose legal status operate with discretionary powers over local affairs within the unitary system of URT (REPOA, 2008). Similarly, local government Authority was established under Article 145 of the Constitution for the purpose of exercising powers of the people in different levels District Authority and Urban Authorities according to Act, 1982. According to the Act, 1982, the administration of District Authority include District council, Township council, village council or Kitongoji (Mnyasenga, 2017). On the other hand, the local government Urban Authority implies city council, municipal council and town council (Ibid). It is under such circumstances that whenever the issue of local government is invoked by no way the decentralisation is as well implied.
2.2.1 Decentralisation and LGAS

There is a linkage between the practice of decentralisation policy and the actualisation of local government authority. It normally happen in the course of studying the interlink of the central-local government. If the concept decentralisation implies transfer of authority and responsibility from the central government to local Authority, then the decentralisation process is a prerequisite medium through which the devolvement could undertake (Schneider, 2003). In the words of Mawhood and Smith (2009) the term decentralisation is any act done by the central government to formally give powers to actors and institutions at lower levels in administrative, political and territorial hierarchy. It may involve the transfer of powers to make decisions regarding administrative issues from the central public authorities to local government authorities that have decision making powers.

2.3 Concept of Health Care Services

The delivery of health care services involves aspects related to curative, preventive, promotive and rehabilitative programmes. It targets at ensuring access to medical assistances in dispensaries, health centers and hospitals in the broadest sense. The health care services are not only bound to medical centers but also extend to mainstreaming people at risk of acquiring disease both physical and mental. It also involved reproductive health services, sensitisation of risk behaviours and conditions that may result to unhealthy or weak circumstances. Tanzania Government is not alien in recognizing the values of health care services since its independence. In responding to the demands of the international accords on achieving the global health for all by the year 2000 a declaration was made in Alma-Ata in 1978. Other international bodies that pushed to deal with health of people is the WHO and UNICEF which sponsored the Bamako initiative. The Bamako initiative proposed country governments to decentralise the health care services delivery thereby strengthening the role of community to take part in cost sharing to access health care services. Notwithstanding the need of the government to increase the delivery of health care service delivery in quality and quantity, the Ministry of Health,
Community Development, Gender, Elderly and Children (MoHCDGEC) in collaboration with the President’s Office-Regional Administration and Local Government (PO-RALG) are charged to ensure provision of health care services to all people but with much priority on the special groups including women.

2.3.1 Health care management and provision in Tanzania

The healthcare service delivery in Tanzania is provided on different levels from the national to the village or community level. Each level consists of a particular staffing entity that is response for management and coordination of the delivery of the healthcare service. According to the National health policy of 2007 and the structure of healthcare system service delivery is organised from the ministry of health, community development, gender, elderly and children (MoHCDGEC) together with the President's Office Regional Administration and Local Government (PO-RALG). In other words, the health system is categorised into three structures namely district and local, secondary and tertiary and the third is the central or national level as described in Table 2.1.

Table 2.1: The structure of health system in Tanzania

<table>
<thead>
<tr>
<th>Level</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>District and Local</td>
<td>The district hospital, health centers, dispensaries, and community health services</td>
</tr>
<tr>
<td>Secondary and Tertiary</td>
<td>Secondary and tertiary hospitals, providing specialty care, and other tertiary-level institutions (teaching institutions);</td>
</tr>
<tr>
<td>Central or national</td>
<td>Provides support services such as policy-making, donor coordination, and monitoring and evaluation.</td>
</tr>
</tbody>
</table>

Source: URT, (2009)

The study identified five levels which govern the management of healthcare services delivery. To state from the lowest to the highest level such as the dispensary, health Center, District Hospital, Regional Hospital, Regional Referral Hospital and National hospital(URT,2014). According to REPOA (2008) every health facility must be placed under the guidance of the health committee or board as to oversee the provision of services to users as well identifying priorities.
2.3.1.1 Health management at community or dispensary level

The dispensary functions at the village, it comprises of the council health committees and the health board. The dispensary level offers services at the first level for outpatients. The services offered at this level include the outpatients, maternal and child health services and community health services (URT, 2009). URT (2014) the structure of the health service staffs in the dispensary includes the administration officers, clinical officer, Nurse, Laboratory technician, Pharmaceutical assistant, Medical attendant and community health worker.

2.3.1.2 Management of Health system at the Ward level

The wards are supposed to have health centers as to receive patients from the villages referred by the dispensaries around (URT, 2007). The Health center is the second level of healthcare service that receives both outpatients and in patients like maternal and child services. It is the first center for dispensary in its location. The health center contains the outpatient department, maternal and child health, medical service, obstetrics theatre, wards with at least 24 beds, diagnostic services, mortuary and surf-burner (URT, 2011). The structure of health center staff is comprised of Medical doctor, Assistant Medical Officer, Radiographer technologist, clinical officer, assistant nursing officer, nurse, ophthalmic nursing officer, optometrist, medical recorders, medical attendant, health laboratory technologist, assistant pharmaceutical technologist, Assistant Dental Officer, Dental therapist, Assistant social welfare officer, Community health Worker, and assistant Environmental health officer. Other staffs include Mortuary attendant, data clerk, revenue collector, health insurance expert and account assistant (URT, 2014).

2.3.1.3 The council Health Management Team (CHMT)

The CHMT is concerned with the management of health delivery at district level, and it is responsible for coordinating preventive, curative, rehabilitative, supervision and promotion of healthcare activities. The CHMT comprises of core and co-opted members. It also has to standing committees; the management committee and the
technical committee. The staffing levels of the core members and co-opted members are represented in Table 2.2 below:

<table>
<thead>
<tr>
<th>S/N</th>
<th>Status</th>
<th>Titles</th>
<th>Staffing levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>core</td>
<td>District medical officer</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>core</td>
<td>District nursing officer</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>core</td>
<td>District health officer</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>core</td>
<td>District health secretary</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>core</td>
<td>District Laboratory Technician</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>core</td>
<td>District Pharmacist</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>core</td>
<td>District dental officer</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>core</td>
<td>District social Welfare officer</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Co-opted</td>
<td>Medical officer In-charge</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Co-opted</td>
<td>District cold chain operator</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Co-opted</td>
<td>Nursing Officer In-charge</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>Co-opted</td>
<td>District TB and Leprosy Coordinator</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>Co-opted</td>
<td>District Mental health coordinator</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>Co-opted</td>
<td>District eye coordinator</td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td>Co-opted</td>
<td>District Reproductive and child health coordinator</td>
<td>1</td>
</tr>
<tr>
<td>16</td>
<td>Co-opted</td>
<td>District AIDS coordinator</td>
<td>1</td>
</tr>
<tr>
<td>17</td>
<td>Co-opted</td>
<td>Hospital health secretary-District hospital</td>
<td>1</td>
</tr>
<tr>
<td>18</td>
<td>Co-opted</td>
<td>District radiographer coordinator</td>
<td>1</td>
</tr>
<tr>
<td>19</td>
<td>Co-opted</td>
<td>Accountant</td>
<td>1</td>
</tr>
<tr>
<td>20</td>
<td>Co-opted</td>
<td>Information, education and communication coordinator</td>
<td>1</td>
</tr>
<tr>
<td>21</td>
<td>Co-opted</td>
<td>Community based Education coordinator</td>
<td>1</td>
</tr>
<tr>
<td>22</td>
<td>Co-opted</td>
<td>Non-communicable disease coordinator</td>
<td>1</td>
</tr>
<tr>
<td>23</td>
<td>Co-opted</td>
<td>Community based education officer</td>
<td>1</td>
</tr>
<tr>
<td>24</td>
<td>Co-opted</td>
<td>Traditional and alternative medicine coordinator</td>
<td>1</td>
</tr>
<tr>
<td>25</td>
<td>Co-opted</td>
<td>Principal training Institution available</td>
<td>1</td>
</tr>
<tr>
<td>26</td>
<td>Co-opted</td>
<td>One representative from regional hospital available</td>
<td>1</td>
</tr>
<tr>
<td>27</td>
<td>Co-opted</td>
<td>District malaria coordinator</td>
<td>1</td>
</tr>
<tr>
<td>28</td>
<td>Co-opted</td>
<td>M &amp; E specialist</td>
<td>1</td>
</tr>
<tr>
<td>29</td>
<td>Co-opted</td>
<td>Private health facilities coordinator</td>
<td>1</td>
</tr>
<tr>
<td>30</td>
<td>Co-opted</td>
<td>Elderly/geriatric services coordinator</td>
<td>1</td>
</tr>
<tr>
<td>31</td>
<td>Co-opted</td>
<td>Nutritionist coordinator</td>
<td>1</td>
</tr>
<tr>
<td>32</td>
<td>Co-opted</td>
<td>Family planning coordinator</td>
<td>1</td>
</tr>
<tr>
<td>33</td>
<td>Co-opted</td>
<td>Research and Global health coordinator</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: URT (2014)

The CHMT is supposed to oversee the provision of health and social welfare services within the overall framework of national policies, guidelines, set standards and under the context of the roles of the health sector in reduction of poverty and contributing to economic development. In view of realising its responsibility the CHMT has two standing committees. The Management committee which is composed of the core CHMT members and the medical officer in charge of the
hospital. The responsibility of the management committee is to ensure quality management of health services at the council level. It is also supposed to advice the council management team in matters related to improvement of and maintenance of health status of people, via planning, implementation, delivery of services and monitoring and evaluation of quality healthcare. The second is the technical committee; it composes of the CHT core members and new members who are given responsibility to manage areas that not yet contained in the CHMT. It is the duty of the technical committees to supervise and discuss the technical and professional issues on quality improvement of service delivery basing on promotive, curative and rehabilitative health services at the council level (URT, 2014).

2.3.2 Women Health Care Services

The health of a woman is very essential for the society because a woman ensures progression of human race. In the World, governments have recognized the importance of providing health care services to women thereby undertaking different approach such as vaccinations against women related diseases and other communicable diseases (Ensor and Cooper 2004). In Tanzania, Shija et al.(2011) describe that the government through the Ministry of Health initiated different programmes like the Primary Health Service Development Programme 2007-2017 for the sake of strengthening health system, rehabilitate health facilities, strive to develop human resources and enhancing the referral systems, equipments and supplies of medicines. Together with the above mentioned programme which covers the delivery of health care service to all people in general, the Ministry of Health by then Ministry of Health and Social Work issued a draft of Maternal and Prenatal Death Audit Guidelines in 2007(URT,2007). The National Health Policy of 2007 in its policy objective 5.3.4 section C, Article (i) pertaining maternal and child birth state that, “the Government in collaboration with private non-profit sector and international partners shall continue to provide free user fee services to pregnant women, users of family planning services and children under five years”(URT, 2007, pp.18).
2.3.3 Decentralisation and Women Health Care Services

The international fora initiated different accords which demanded national governments to respond towards minimizing maternal deaths rates. Among the key initiatives include the UN declaration in 1975 (1976-1985) that intended to improve the status of health of women’s right to health services (FCI, 2007). The other declaration was that of Alma-Ata of 1978 on Primary Health care services. This declaration urged government to promote health of all people but in particular maternal and child health care (WHO, 1978). In Nairobi an international initiative to Safe motherhood was set forth in 1987, though the maternal mortality rate were less considered in the programme, the programme was very crucial to awakening nations on matters of transferring health care services to the regional levels for Women to get access to maternal and child health care. Different comprehensive approaches to health and right of men and women regarding access to quality and sustainable health care services were put forth by other international organisations. It followed the miscellaneous decisions of the Nairobi Accord which overlooked the aspect of reducing maternal mortality in securing the health of pregnant women and child birth survival complications (FHI, 2007). Early in 1994 the International summit on Population and Development was held to discuss matter of reproductive health and right of men and women (Abouzahr, 2003). The chain of conducting international meetings on health care services went on with the intentions to find best ways on which women health could be assured up to the lowest level of the society in the country. In Tanzania the regions were charged to cater for the primary health care services, regional referral hospitals, district hospitals and health centers and dispensaries (Sines et al., 2006; FCI, 2007). All these were set forth by the Ministry of health under the guidance of the National Health Policy (2003).

With the need to bring health care services near to users in the regions and districts the decentralisation programme in health care system introduced different means of cost recovery programmes. They include introduction of different health insurance programmes like the National Health Insurance Fund which operates for both public and private health centers, the Community health fund which operates in the public
hospitals only, other private insurance companies and direct cost sharing practices. The health care service reform programmes have worked to affect the system of health care provision. Recently, the provision of health care services is categorised into three levels of administration. The first is the MoHCDGEC which is charged with the development of the sector policies, regulatory frameworks as well as Health monitoring and evaluation. The second is the PO-RALG which is charged with the institutionalization and professional development and training. The third is the district level which deals with the primary health care service provisions.

2.3.4 Measuring the Quality of Health Care Services

The quality of health care services mainly refers to the standard of services offered in the public health institutions like dispensaries, health centers, hospitals and referral hospital, the district and council levels. In order to understand that there was quality health service provided, there were four issues taken on board. The aspects included: the existence of medical facilities like diagnosis facilities, medicines and other pharmaceutical facilities, the presence of required medical personnel in the dispensary of health centers, the aptness or responsiveness of service providers and the satisfaction level of clients or patient to the services provided (Boex, Fuller and Malik, 2015).

2.3.5 LGAs Roles in Decentralised Women Health Care Services in Tanzania

2.4 Empirical Literature Review

In the review of literature the study scrutinised different authors who worked to investigate on different affairs related to local government authority administration of health care service delivery. In particular, the provision of free health care services to pregnant women in public health centers is the central concern.

Marijani (2017) did a study on the participation of the community in the delivery of water and primary health care services in the local government authorities. It was a descriptive study that used mixed methods. A total of 208 respondents were employed out of whom 127 answered questionnaires, 51 were interviewed and 30
were involved in Focus Group Discussions. In the study, it was found that decentralisation reforms facilitate the formation of health and water service governance structures. In addition, it was found that the means to which the community participated in health service delivery was through taking part in project initiation and management and form membership to health centers boards and committees.

The study conducted by Ngxongo et al. (2016) analysed the experiences and views of pregnant women regarding the antenatal care services received in the primary health care clinics. Its implementation of Basic Antenatal Care (BANC) approaches said to be one of the crucial interventions for the reduction of maternal and child mortality in South Africa. BANC is also used for pregnant women. The study was qualitative that was done in 1 health care clinics that provided antenatal care services and implement BANC approach in different district of SA. Interview method was employed to 54 pregnant women from October 2014 to March 2015. It was said that participant were discontent with the waiting times, the interval between antenatal care visits and integration of antenatal care with other primary health care services. Other observations were small space for clinics and depressing attitudes of clinic staff. In conclusion the BANC approach needed more attention in its actualisation.

Nindi (2015) assessed the challenges in provision of exemptions policy in health service. The study was done at Frelimo Hospital in Iringa municipal council. The study attempted to answer three research questions: to what extent is the exemption policy implemented in health provision in the hospital?, what challenges encountered in implementing the exemption in health delivery? And how can the implementation challenges be addressed? It was a qualitative study that used a case study design. A sample design of 100 respondents was employed including beneficiaries of the health service delivered in the hospital. The judgment and accidental sampling technique were used. It was found that the hospital moderately managed to implement the exemption policy. However, there were challenges associated to poor infrastructures and buildings for the wards and clinic offices. The other problem was shortage of funds to enable the implementation. The pharmacy
department had no adequate plans to ensure availability of drugs in the hospital. Low motivation of the hospital personnel. Clients were dissatisfied with untimely attendance and lack of appropriate prescription and attention. The study recommends the government to make thorough decision to overcome the policy deficiencies, recruit more staffs. Hospital and dispensaries from the peripherals should be improved in terms of work condition and experts.

Kasina (2013) conducted a study in Kenya explore on the access to free maternity healthcare services established in the country. The study investigated on the access to skilled health service delivery, factors for accessibility, affordability and availability of health services. The study looked at challenges faced by pregnant women in accessing and use of free maternal service healthcare in primary health care centers. The study was descriptive exploratory and used both questionnaire and documentary methods. It was revealed that hospitals with health facilities like obstetricians, ambulances, beds and presence of free maternity policy were significant by 1% in increases access to free maternity cares. Midwives and theaters were insignificant in influencing pregnant women to use free maternity services. It was recommended that the ministry of health should increase facility provision in lower health care centers, increase number of staff as to attract pregnant mother to access and use the free maternity services.

Tidemand and Msami (2010:30) while studying the impact of decentralisation in Tanzania found that decentralisation had a positive impact on civic participation which increased trust in local government and financial accountability, and reduced corruption. Others report on specific positive impacts relating to service delivery. For example, Bardhan and Mookherjee (2003) found that decentralisation reduced poverty in West Bengal- India; and Habibi et al. (2001) and Eskel and Filmer (2002:20) found that decentralisation increased access to education and health services in Argentina. Similarly, Faguet (2001:21) found that in Bolivia decentralisation increased accessibility to services which were in line with local preferences. Reporting on their research on the impact of decentralisation in
Tanzania, Tidemand and Msami (2010:31) claimed that decentralisation increased citizens’ satisfaction with public services such as health and education.

Another study by Shija et al. (2011) examined the maternal health in fifty years of Tanzania independence: Challenges and opportunities of reducing maternal mortality. The argument of the study is that maternal death makes one of the major public health concerns in Tanzania. The cicatrizes of maternal deaths are accentuated by some factors related to pregnancy, childbirth and poor quality of health services. The study suggests that provision of health care in particular maternal care can help to reduce maternity deaths by 80%. The central objective of the study was to analyse the maternal mortality situation in Tanzania. It was mentioned that the maternal mortality decreased from 453 in 1961to 200 per 100,000 in 1990. Data further show that 96% of pregnant women attend antenatal clinic at least once. However, the study indicated that there is inadequate access to maternal health care services in favour of reducing maternal deaths strategies including strengthening the health systems to provide skilled attendance during childbirth, upgrading rural health centers to provide emergence obstetric services, provide adolescent and male friendly family planning services, strengthening public-private partnership to ensure progress of care. Other strategies include enhancement of community participation and women empowerment. The study concluded that maternal mortality rate in Tanzania should focus on assuring continuum of care through quality health system, improved referral health system and operation research.

2.5 Research gap

In the analysis of the empirical studies, there are studies that have provided light on the issue of pregnant women but on the perspectives of reducing the mortality rates through access to Basic Antenatal Care as seen from Shija et al. (2011) , Ngxongo et al. (2016) and Kasina(2013) while other study elaborated on the implementation of decentralisation policy in water and health services Nindi,2015; Tidemand and Msami (2010). These studies despite their noted contributions on the methodological approaches for the prospective study, they have not dwelt concretely on the analysis
of the influence of LGAs and decentralisation on the provision of free health care services to pregnant women. They have however, helped to inform the study on the essential need to provide health care services to vulnerable groups with less articulation on the free health care provision to pregnant women who form the central focus of the prospective study.

2.6 Conceptual Framework

The theoretical frameworks provided way forward for the development of conceptual framework. The role and influence of the local government authority is the independent variable and the management of health care services for the pregnant women is dependent variable. The demographic characteristic of pregnant women play the background role in determining the ability to access health services due to social network and economic affluence. The background variables affect both independent and dependent variables such that if the woman is educated, she can easily access such services because of being in a position to get information easily through networks and also being in areas where such services are accessible than uneducated women who mostly live in rural or remote areas where most of health services for pregnant women may not be available or may be of poor quality.

In Figure 2.1, the roles and influence of the local government constitute the independent variable. It is indicated by the roles, structures and procedures of LGAs in administration of healthcare services, quality of free health services provided to pregnant women and roles and influence of LGAs on assuring free healthcare services provision to pregnant women. The dependent variable is the management of the free health care services to pregnant women. It was assessed by looking at the access to free healthcare services by women in terms of affordability, availability of medicines and medical services such as tetanus injection, Malaria, TB and HIV/AIDS, and promptness of the services. The free health care services provide chance for pregnant women to afford health services, since they have to depend on the government subsides.
Figure 2.2: Conceptual Framework

**Independent variable**

- The influence of Local government Authority
  - The roles of LGA leaders in healthcare service delivery
  - Structures of the LGAs healthcare provision for pregnant women
  - Procedures used by LGAs to deliver health care services to pregnant women
  - Quality of free health care service delivered to pregnant women
  - Roles of LGA in administration of free healthcare service to pregnant women

**Dependent variable**

- Maternal healthcare provision of Decentralised free health care services
  - Access to free health care services for pregnant women
  - Knowledge of LGA responsibilities, and procedures in the healthcare delivery
  - Availability of medicines and medical services
  - Promptness of the service providers
  - Kinds of curative and preventive health services provided
  - Declarative actions in favour of pregnant women

**Background Variables**

- Age of the pregnant woman
- Education level
- Income level
- Occupation status

Source: Literature reviews, 2019
CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The chapter describes the methodological aspects used in the study. It includes the research design, area of the study, measurement of variables, sampling techniques, sample size, methods of data collection and analysis, the validity and reliability of data and finally the ethical considerations in the actualisation of the study.

3.2 Research Design

The study applies descriptive case study design. The case study design is selected because it facilitates collection of data by use of mixed methods. It also suitable for the study since it allows the researcher to have field experience only once and get ready for report writing; hence it is time economic (Jupp, 2006).

3.3 Study Area

The study was carried out in Dodoma City and involved the health centers and dispensaries owned by the government. The selection of the study area was due to absence of any empirical study that assessed the influence of LGAs in provision of health care service to pregnant women. In addition, the place is recently raised to the level of the city hence the need to understand its ability to cater for free health care services for the vulnerable groups including pregnant women.
3.4 Measurement of variables

### Table 3.1: Measurement of variables

<table>
<thead>
<tr>
<th>s/n</th>
<th>Variable</th>
<th>Indicators/measurement method</th>
<th>Expected results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Roles, Structures and procedures of LGAs in health care service provisions</td>
<td>Roles of LAGs in free health care services provision to pregnant women</td>
<td>Narrative and Descriptive data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Structure of LGAs health care service delivery</td>
<td>Nominal data and narrative information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Procedures used by LGAs in provision of free healthcare services to pregnant women</td>
<td>Narrative information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to free health care services to pregnant women</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Quality of free health care services provided to pregnant women</td>
<td>Affordability of the health services provided to pregnant women</td>
<td>Descriptive numerical data and narrative information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Status of the medical services provided freely to pregnant women</td>
<td>The nominal data and narrative information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Availability of medicines and curative treatments</td>
<td>Descriptive numerical data and narrative information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promptness of service providers</td>
<td>Narrative information with some descriptive data</td>
</tr>
<tr>
<td>3</td>
<td>Role and influence of LGAs in management of free health care services delivery to pregnant women</td>
<td>The level of information dissemination of free health care services to pregnant women</td>
<td>Narrative information with some numerical descriptive data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declarative actions /role that LGAs play to ensure delivery of free healthcare services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The level of influence of LGAs on provision of free healthcare service delivery</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Researchers construct (2019)

3.5 Study Population

The population of the study was health stakeholders. It was comprised of all pregnant women attending clinics, workers of health care facilities, and officials from Dodoma City.

3.6 Sampling frame

The sampling frame comprised the pregnant women attending clinics in Mkonze, Makole, Hombolo health centers and Kikuyu and Ihumwa dispensaries. It also involved workers from the health centers, health secretaries from the city of Dodoma, the city medical officer of health from Dodoma City.
3.7 Sampling techniques

The study employed a non-probability sampling to select the required respondents for the study. The application of non-probability sampling techniques was essentially preferred as to respond to the nature of respondents to take part in the study. The research participants could best be attaining by judgmental sampling design since they could hardly be randomly sampled. In particular the purposive and convenience sampling techniques were employed in the study.

3.7.1 The purposive sampling

The purposive sampling technique is an appropriate way of selecting a sample basing on the knowledge of the population and the purpose of the study. The purposive sampling could also be defined as a non-probability in which decisions concerning the individuals to be involved in the sample as selected by the researcher basing on the variety of the criteria such as knowledge of the participants, capacity and willingness to participate in the research conduct as respondents or sources of data (Juppe, 2006). The study used the purposive sampling technique to select city medical doctor officer, medical doctors in health centers, city health executive officers, health secretaries in hospitals and the municipal director. The purposively selected participants are expected to possess relevant information about the practice of health service provision for pregnant women and the role the local government plays in health care management and provision to them.

3.7.2 Convenience sampling design

The convenience sampling design is among the judgmental techniques whereby, respondents are picked basing on their availability at the spot where data were gathered. The convenient sampling design was mainly used to select pregnant women who were found the health centers and dispensaries for clinical services. The choice of this sampling technique was due to the fact that pregnant women could only be summoned at the health centers to look for health services especially
in hospitals, health centers and dispensaries. Virtually, the researcher found respondents in the course of visiting health centers.

### 3.7.3 Sample size

The sample size that was used in the study is 120 respondents drawn from different categories as shown in table 3:1. According to the Household population censor of 2012, the Dodoma City had 211469 women (URT, 2012). Pregnant women receiving health care services in various public health care facilities in the City form part of that population. To this regard, the accidental sampling technique facilitated the attainment of 100 pregnant women as the sample size that represented the rest of the population of pregnant women in the city. In addition, the sample included the one City medical officer (CMO), 3 the City Health secretaries, 4 medical doctors/officers in charge of pregnant women, and 3 nurses from five health centers summing up to 24 participants. Out of the 24 health official only twenty were availed during the course of study hence accumulating the number of respondent to be 120. The study used the biggest sample size compared to other previous scholars who conducted the similar study on pregnant women. Kasina (2013) used a sample size of 63 pregnant women in Iringa, and Nindi (2015) used a sample size of 40 pregnant women in Lindi. It followed that the present study used a sample size of 100 pregnant women plus 20 other participants as shown in the study table 3.1.
Table 3.2: Sample Size

<table>
<thead>
<tr>
<th>Sample Category</th>
<th>Total Number Of respondents</th>
<th>Selected</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees from Dodoma City Council Health Management Team</td>
<td>32</td>
<td>4</td>
<td>12.4</td>
</tr>
<tr>
<td>Employees from Mkonze Health Center</td>
<td>29</td>
<td>4</td>
<td>13.8</td>
</tr>
<tr>
<td>Employees from Makole Health Center</td>
<td>32</td>
<td>4</td>
<td>12.4</td>
</tr>
<tr>
<td>Employees from Hombolo Health Center</td>
<td>30</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Employees from Kikuyu Dispensary</td>
<td>20</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Employees from Ihumwa Dispensary</td>
<td>23</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Pregnant Women attending clinics in Mkonze Health Center</td>
<td>20</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>Pregnant Women attending clinics in Makole Health Center</td>
<td>18</td>
<td>17</td>
<td>83.3</td>
</tr>
<tr>
<td>Pregnant Women attending clinics in Hombolo Health Center</td>
<td>25</td>
<td>24</td>
<td>88</td>
</tr>
<tr>
<td>Pregnant Women attending clinics in Kikuyu Dispensary</td>
<td>15</td>
<td>14</td>
<td>86.7</td>
</tr>
<tr>
<td>Pregnant Women attending clinics in Ihumwa Dispensary</td>
<td>22</td>
<td>21</td>
<td>90.9</td>
</tr>
<tr>
<td>Total</td>
<td>266</td>
<td>120</td>
<td>45.1</td>
</tr>
</tbody>
</table>

Source: Field data (2019)

3.8 Methods of data collection

The study sought both the primary and secondary data. The primary data was collected by the use of questionnaires and interviews. The secondary data was collected by the use of documentary review.

3.8.1 Questionnaire method

The questionnaire method was used to collect data from 100 pregnant women and 12 nurses. It involved semi-structured questions that provided open-ended and closed ended questions. The design for the questionnaire was in relation to the study objectives. The need was to get pregnant women and nurses who could not be easily accessible for interview method. The semi-structured questionnaires were simple to administer and its analysis was also relatively easy to carry (Kothari, 2004).

3.8.2 Interview method

The interview method facilitated gathering of narrative data. Interviews are understood to be effective methods that facilitate excavation of the social
phenomena which could not be easily attained by mere observations (Patton, 2002). It was used in the study to gain in-depth information on the influence of LGAs on the management of free healthcare service to pregnant women. The interview key informants were the CMO, medical doctors/officers and Health secretaries. The study used semi-structured interviews as to gain rich information from respondents. The interview guide was developed in line with the three research objectives for the study.

3.8.3 Documentary review

Documentary reviews are also used to collect secondary data that might not be collected by another instrument. According to Singh documentary review deals with the systematic examination of current records or documents as sources of data. In documentary analysis, the following may be used as sources of data: official records and reports, printed forms, text-books, reference books, letters, autobiographies, diaries, pictures, films and cartoons (Singh, 2006). The study reviews the log register book for pregnant women, government circulars on maternal health care service delivery, the municipal strategic plan on health service delivery and minutes of the local government council regarding health service delivery if accessed.

3.9 Data Analysis procedures

The collected data were subjected to analysis techniques. Data collected through interviews was analysed by the use of content analysis method. The aim is to get narrative information which is grouped into categories and themes. Audio data was transcribed, translated, coded and the further was subjected to formation of categories basing on the specific objectives.

The data gathered through questionnaire were analysed by the use of descriptive statistical analysis. The quantitative data were analysed in the computer using a statistical package for social science (SPSS) to draw the descriptive results using frequencies, cross-tabulation and percentages. Generally the cross-tabulation was
used to elucidate the relationships between independent variables and the dependent variable.

3.10 Validity and Reliability of data

It is useful to control the validity of data collected in order to have validity findings and conclusions. The validity of the study implies degree of exactitude that data communicate about the study. To attain valid data the researcher applied appropriate tools to measure appropriate variables. In the course of assuring valid data the tools were scrutinised and modified to suit the specific objectives. In addition, correct selection of respondents was useful to validate the quality of truth to which data possess.

Reliability implies range of consistence of the instrument in measuring the required object or phenomenon. According to Ndunguru (2007) reliability means the extent to which a measure is giving consistent and stable results in a measurement process. The correct use of data collection methods to the assigned variables facilitated the attainment of reliable data. In view of sustaining reliability of data, pilot study was used for the instruments to be studied outside field as to find out if the questions were disposed to provide the clear answer. Questions in the interviews and questionnaire were framed to make data consistent.

3.11 Ethical Considerations

The observation of ethical principles in research conduct is essential to validate the soundness of the study findings. In the course of research, different ethical principles were observed. The study avoided plagiarism, and misuse of improper terminologies in proposal authorship. Upon the completion of the proposal document, the researcher sought for research permit to go for data collection. While in the field the some of the ethical principles were taken on board. They included provision of research information and sought for informed consent from the participants, keep appointment of the respondents, respect of respondent’ opinions, punctuality to field appointment and have descent appearance in the filled work.
The researcher observed different ethical issues related to data analysis, report writing and dissemination like respect of anonymity of respondents, avoid biased reporting and maintenance of confidentiality.
CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

The chapter presents the results and findings of the study. It starts by providing the demographic information of the respondents, and then followed with the findings from the analysed data. The presentation follows the system of specific research objectives. The first objective assessed the roles, structures and procedures of LGAs in management of health care services, the second objective examined the quality of health care services delivered to pregnant women and the third objective assessed the roles and influence of local government authority in Dodoma City Council on provision of free health care services to pregnant women.

4.2 Demographic characteristics of respondents

The social-demographic profile of respondents based on age distribution, education level, occupation status and income status, as well as work experience for the key informant. The information about respondents’ socio-demographic profile was deemed necessary as they compose the background information about the beneficiaries of the delivered health service and the professional level of the health service providers. The structure of presentation is divided into two categories: One hundred and twelve respondents who filled the questionnaires and the eight key interview informants, thus the presentation starts with the questionnaire respondents then follows the interview key informants.

4.2.1 The age distribution of respondents

The age of respondent was sought as to understand the average age group of pregnant women. In the study, the age of the respondents presupposed the maturity level and ability to provide information basing on personal experience about the services delivery in health centers. Figure 4.1 portrays that a dominant age group of
112 respondents was that of 16-25 years (58%), followed by that of 26-35 years (28%) and lastly few pregnant women aged 36-45 years (14%).

**Figure 4.1: Age group profiles of respondents**

![Pie chart showing age distribution]

*Source: Field data (2019)*

In the analysis of the information provided in age, the study found that the large proportion of pregnant women in Dodoma city conceived at a tender age which suggest the possibility of teen pregnancies since 58% of pregnant women are aged between 16-25 years, 28% of the respondent pregnant women range from 25-35 years and 14% of respondent pregnant women are aged between 36-45 years.

**4.2.2 Education level of respondents**

Respondent’s level of education was found useful in understanding the level of information and alternatives to access health care services in health centers during pregnancy time. Respondents were asked to tell their highest level of education attained and their answers were presented in Figure 4.2.
Figure 4.2: Respondents’ Profile by Education Levels

![Graph showing education levels of respondents]

Source: Field data (2019)

Figure 4.2 shows that 41% of respondents had a secondary education level, 28% had primary level, 22% of respondents reached a college level and 9% of respondents had university degree. Impliedly, the predominant percentage of pregnant women who attained the basic education primary and secondary levels was 69% and those with tertiary education were ranked to 31% of respondents.

4.2.3 Occupation status of respondents

The search for knowledge of respondents occupation status due to the assumption that kind of work is useful in predicting and describing the ability of the individual to have information about health, have alternative access to health care services by health insurance and also it entails the possibility of the individual to attend health care services from public or private health centers. Table 4.1 provides brief description of the results derived from respondents.
### Table 4.1: Occupation status of respondents

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public servant</td>
<td>39</td>
<td>34.9</td>
</tr>
<tr>
<td>Private servant</td>
<td>11</td>
<td>9.8</td>
</tr>
<tr>
<td>Peasant</td>
<td>37</td>
<td>33.0</td>
</tr>
<tr>
<td>Small business</td>
<td>25</td>
<td>22.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>112</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**Source:** Field data (2019)

The majority of respondents were public servants (34.9%), peasants (33%), followed by business entrepreneurs composed 22.3% of respondents and private servants/employee composed 9.8% of the respondents. During the field work, it was observed that most of those who mentioned to be Small business were household mothers dealing with petty trades like making pancakes, selling vegetables and bananas.

#### 4.2.4 Income level of respondents

The income level of respondents determined the ability to afford expenses of health care services either by cash or credit or accessing other health insurance service providers. Though the provision of free health care services is open to all pregnant women, the greater attention is put on those in poor conditions as a means to help them to access health services with no or very minimal costs. The results shown in Figure 4.3 suggest that majority of pregnant women respondent have low income status.
From Figure 4.3 seventy percent of respondents had a monthly income of below 400,000 Tsh, 19% had the income range of 400,000-800,000 Tsh, 10% reported to have an income of 800,000-1,200,000 Tsh and only 1% of the respondent had an income level of 1,200,000-1,600,000 Tsh. The dominant group of respondent was found to have low income level which suggests low purchasing power and higher dependence on government cheap or free user fee services.

In sum, the socio demographic characteristics of respondent was found to portray different features regarding the level of understanding about the practice of providing free health care service to pregnant women in Dodoma city council. Among others, was that the dominant age group of the majority of pregnant women was between 16-25 by 58%, the respondent with secondary education were many by 41% followed those with primary level by 28% hence making a total of 69% respondent with basic education level. Respondent’s occupation was found to be evenly distributed from employed and private worker, such that the sum of peasant and small business entrepreneurs composed to 62% versus 38% of pregnant women.
employees from public and private sectors. It entails that a good number of women under self-employment have tendencies to attend healthcare services from public health centers as compared to the rest who could have alternatives to attend to private health centers. Their income level was also a determinant factor in the background in pushing those with low income who compose the majority of the respondents (70%) to seek for free health care services.

4.3 The roles, structures and procedures for provision of free health care services to pregnant women in Dodoma City

The first objective of the study intended to assess the roles, structures, and procedures for provision of free health care services to pregnant women in Dodoma City Council. This objective entailed the identification and assessment of the roles, structures for provision of free health care services to pregnant women, the roles played by Dodoma City Council in provision of free health care services to pregnant women, and procedures set by Dodoma City Council to ensure free health care provision for pregnant women. This objective was first investigated through face to face interviews with the key informants and documentary reviews. The findings from interviews and documentary reviews showed that the Dodoma City Council performs its roles within a structural frameworks and procedures that have been stipulated in various laws and policy documents.

4.3.1 The roles and structure of Dodoma city CHMT

Basing on the words of the City medical officer the management of health care services to pregnant women follows the subsidiary principle which requires transfer of the decision making powers and responsibility to manage the health services to the lowest levels.

Reviews of documents demonstrate that regarding the structures of Dodoma City Council is coordinated by the Council of Health Management Team. It is the key actor and overseer of all activities related to management and provision of health care services including the free health care services to communities in Dodoma city.
The City Council manages health care services including the free health care services to pregnant women through Council Health Management Team, which is the highest decision making organ for all issues related to health services management and provision in the city. The CHMT is composed of core members and co-opted members who enter into the council by virtue of their positions. Table 4.2a-c present the structure and responsibilities of CHMT present in Dodoma city council.
### Table 4.2a: Structure and roles of Council Health Management Team

<table>
<thead>
<tr>
<th>1. District medical officer</th>
<th>2. District nursing officer</th>
<th>3. District health officer</th>
<th>4. District health secretary</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Chief adviser of the city council director on all matters of health</td>
<td>i. To advice and monitor implementations of nursing directives and criteria in the council.</td>
<td>i. Advise the Chief Medical Officer of the Municipality/city for all aspects of the Sanitation in the District / Board</td>
<td>i. Provide administrative and management advice on daily matters of health to health staffs and stakeholders.</td>
</tr>
<tr>
<td>ii. The overall supervisor of all professional health issues from the city to the community levels.</td>
<td>ii. Strict follow-up to ensure that all nurses provide health care service as required by the nursing codes of conduct.</td>
<td>ii. The Chief Administrator of all aspects of health Intellectual Environment hierarchically at District / Council to the community.</td>
<td>ii. Keep all records of health department including vehicles, public employees, tools, calendars, infrastructure, finance and other briefs that could help CHMT to make decisions.</td>
</tr>
<tr>
<td>iii. Leader of the CHMT in the city and district.</td>
<td>iii. To provide technical advice on issues pertaining to nursing and other health professions.</td>
<td>iii. Manage sanitation at the district level, ward, local, health centers and dispensaries in the district / Council</td>
<td>iii. To regulate and assist in preparations of programmes in the health department.</td>
</tr>
<tr>
<td>iv. To administer and assurer of the quality health service delivery in the council from the dispensary to the hospital centers.</td>
<td>iv. To provide technical advice and to supervise the directive of policy implementation in the council.</td>
<td>iv. Prepare all information relating and Sanitation at District / Board and submit to the relevant authorities.</td>
<td>iv. To regulate drafting of health budgets in the council.</td>
</tr>
<tr>
<td>v. To prepare health report at the council level.</td>
<td>v. To coordinate professional sector as directed by the district/ city medical officer.</td>
<td>v. Participate in the preparation of a Master Plan for Health (CCHP) and ensure interventions related to hygiene executions.</td>
<td>v. To prepare and submit health management report on monthly, quarterly and annual basis</td>
</tr>
<tr>
<td>vi. Chief administrators of human resources, finance, infrastructures, facilities and medicine in the council.</td>
<td>vii. To participate on drafting of health programme on nursing sector improvements in the council.</td>
<td>vi. Provide interpretation of policies and guidelines of the government in relation to matters of hygiene.</td>
<td>vii. To coordinate interactions between health centers, community and the council.</td>
</tr>
<tr>
<td>vii. To manage and advice the implementation of health programme in collaboration with other health officers and stakeholders.</td>
<td>viii. To coordinate, analyse and manage health statistics and records and avail them wherever needed.</td>
<td>Manage and prepare strategies to deal with the outbreak of diseases in the district / council.</td>
<td>ix. To supervise and guide timely inspection and audits on areas assigned by the superior.</td>
</tr>
</tbody>
</table>

Source: Field Data (2019)
Table 4.2a shows the major roles of the members of CHMT are to advice on health management and delivery, to monitor and supervise, to administer and lead implementation of health policy and directives, to keep records and provide interpretation of the government policies and directives. The other roles include participating in council budget drafting and approval, coordinating interactions between the council, health centers and community members. Members mentioned in Table 4.2a are also participant of the management committees of the CHMT.

The structure of the Dodoma city council is further formed by other technical experts who deal in laboratory, pharmacy, and social welfares. There staffing levels and roles are described in Table 4.2b.
<table>
<thead>
<tr>
<th>5. District Laboratory Technician</th>
<th>6. District Pharmacist</th>
<th>7. District social Welfare officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Advise the Municipal Medical Officer for all matters relating to laboratory services in the District / Board.</td>
<td>i. Manage the importation, procurement, storage and distribution of drugs and medical supplies district / council’s work.</td>
<td>i. Provide interpretation of policies, guidelines and procedures provided by MOHSW related to the issues of Social Welfare and oversee its implementation in the District / Board.</td>
</tr>
<tr>
<td>ii. Participates in preparing the Health Master Plan (CCHP) and ensure laboratory activities are included in the program.</td>
<td>ii. Advise the Chief Medical Officer via Teams on the best methods to improve drug unit in the district / council’s work.</td>
<td>ii. Assistance Teams to identify vulnerable groups that need special attention Teams enough that it can develop a plan to deal with.</td>
</tr>
<tr>
<td>iii. Provide interpretation of policies, guidelines and procedures provided by MOHSW related service issues Laboratory.</td>
<td>iii. Keep records of medicine to the district level and put them already there zitakohitajiwa Teams for making decisions.</td>
<td>iii. Prepare a program to assist less capable groups that might need for free health care either helped to strengthening Health Teams Fund Category.</td>
</tr>
<tr>
<td>iv. Manage all technical issues related to laboratory services, including advice to solve the problems of testing, maintenance of laboratory equipment and to assess the quality of laboratory services (Ensure quality) according to the guidelines of the Council of Tanzania laboratory.</td>
<td>iv. Supervise the proper use of drugs at all levels.</td>
<td>iv. Educate the community about the importance of using health services, especially to manage the government’s free treatment to specific groups.</td>
</tr>
<tr>
<td>v. Supervise and inspect all government and private laboratories existing in the District / Board.</td>
<td>v. Provide information on the side effects of medication use (Adverse drug reaction)</td>
<td>v. Distribute and manage new government guidelines to be made known to start implementation by stakeholders.</td>
</tr>
<tr>
<td>vi. Organise information relating to laboratory and submit them to the relevant authorities in accordance with the guidelines of implementation.</td>
<td>vi. Cooperating with authorities food and drugs (TFDA) in reviewing the standards, quality and safety of food, including checking, manufacture, storage, transport, distribution and consumption of food products.</td>
<td>vi. Prepare and submit timely information relating to social welfare in relevant authorities.</td>
</tr>
<tr>
<td>vii. To report to the General Physician Teams work in the laboratory as mandated by City council Health plan CCHP.</td>
<td>vii. Educate his subordinates, other employees of the health sector and the community on the proper use of medications.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>viii. Manage the implementation of the National Drug Policy in the District / Council's work.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ix. Prepare and submit reports of his unit in the competent authorities in timely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>x. Perform regular audits, management, guiding and evaluation of all areas of the pharmaceutical service providers in the District / Board</td>
<td></td>
</tr>
</tbody>
</table>

Source: URT (2014)
Table 4.2b presents the structures of CHMT members who play technical roles specifically on laboratory, pharmacy and social welfares in the city. Each of the assigned roles are simply geared towards provision of and management of health service delivery, consultancy and advisory, supervision of all laboratories, and pharmacies of medical shops present in the city as well as identification of special or vulnerable groups to be catered for in the health services delivery. Pregnant women are therefore part of the vulnerable groups who are beneficiaries of the free health care services.

The other roles are dealing with coordination of different aspect of health such as malaria, reproductive health and children and TB and HIV/AIDS coordinators. Table 4.2c provides the categories of the structure of CHMT dealing with different coordinative functions.
Table 4.2c: The structure and coordinative roles of CHMT in Dodoma city

<table>
<thead>
<tr>
<th>District Reproductive and child health coordinator</th>
<th>District malaria coordinator</th>
<th>District TB and Leprosy Coordinator</th>
<th>District HIV/AIDS coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. To advise and oversee the implementation of policies and directives offered by MOHSW issues related to maternity care and child</td>
<td>i. Manage all activities of malaria control in the Council.</td>
<td>i. Make sure the medicine and supplies related to the treatment of tuberculosis and leprosy are required to timely and accessible all the time</td>
<td>i. Collect, Organise, analyse and present information related to the local level according to existing guidelines</td>
</tr>
<tr>
<td>ii. Make close monitoring to ensure nurses give health care based on the values of the profession of nursing (adherence to professional code of conduct of all nursing staff)</td>
<td>i. Provide training and guidelines to interpret the new malaria treatment offered by MOHSW for different groups of patients and monitor their implementation</td>
<td>ii. Coordinate treatment of tuberculosis and leprosy in all stations Throw up such services within the Council</td>
<td>ii. Provide technical advice on the best methods to improve AIDS control activities in the council.</td>
</tr>
<tr>
<td>iii. Provide technical advice on working relationships between nurses and other health cadres at all levels of the District / Board.</td>
<td>ii. Participate in the preparation of the Master Plan for Health and Ensure combat operations and malaria are included to ensure that enforced.</td>
<td>iii. Make management guiding in centers providing services health professional to inspect sites and provide advice on improving treatment for patients</td>
<td>iii. To manage, translate and distribute new guidelines and policies relating to the control of HIV / AIDS, in the council.</td>
</tr>
<tr>
<td>iv. Advise the Chief Medical Officer via Teams on the best strategies to improve maternity care and child especially in the whole concept of reducing deaths of pregnant women and infants</td>
<td>ii. Coordinate the preparation, filling and reporting of malaria in council management guiding</td>
<td>iv. Participate in the preparation of the Health Plan (CCHP) and make sure the core business of the epidemic are included and will be responsible for overseeing implementation of the Health</td>
<td>iv. Participate in the preparation of the Health Plan (CCHP) and make sure the core business of the epidemic are included and will be responsible for overseeing implementation of the Health</td>
</tr>
<tr>
<td>v. Manage, evaluate and organise information for maternal health and child in the District / Board according to existing guidelines (week, month, quarter and year).</td>
<td>v. Make stations offer the service to see the status of service delivery and provide professional advice.</td>
<td>v. Prepare and submit a report on the progress of activities unit of TB and leprosy to the relevant authorities</td>
<td>v. Involve stakeholders in AIDS control strategies to ensure sustainability becomes the guiding</td>
</tr>
<tr>
<td>vi. Make management guiding in professional areas will be assigned to him by the DMO.</td>
<td></td>
<td></td>
<td>vi. Make management in the field of provision of HIV services and to report to the Chief medical Officer via Teams on the progress of activities undertaken in the fight against HIV (status of Implementation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>vii. Manage the delivery of HIV treatment to all customers within the District / Council for all levels (stations government and private, FBOs or any groups involved in the anti-HIV activity) to ensure the availability of reagents for HIV testing and regulating its use in Council</td>
</tr>
</tbody>
</table>

Source: Field data (2019)
The roles stipulated in Table 4.1a, b and c are also stated briefly in the National health policy of 2017. The Policy state that “the council Health Service Boards and committees embedded under CHMT Council are crucial decentralised structures at the grassroots level” (URT, 2017). The policy goes further to state the responsibilities of council health management Team and boards as follows:

These structures are obliged to discuss and approve facility plans and budget, identify and solicit financial resources, provide advice and recommend on human resources regarding recruitment, training, selection and deployment to relevant authorities. The council is also central in assuring quality of service delivery and therefore has mandate to receive reports, draft comprehensive plans, transport medicines and medical facilities as well as coordinating, implementing and monitor and evaluate health services in collaboration with the community and other stakeholders in the council (URT, 2017).

4.3.2 Structure of health system in Dodoma city council authority

According to the Ministry of Social Welfare (MOHSW, 2014) the health system in Tanzania is organised into three major roles community-level health facilities, secondary and tertiary hospitals and centralised policy-making and monitoring. The structure of health system is adopted in every local government authority particularly from the village to district or council level. It follows that the community level host patients for the first moment of visits and then referred to the higher levels when the need arises. In Dodoma city council, the health system management delivery is composed of three levels in its structure: the Dodoma city referral hospital, Health centers and dispensaries as provided in Figure 4.4.
Figure 4.4: Structure of health system in Dodoma city council authority

Source: Field data (2019) Key: Disp= Dispensary, CHC= Community health committee

From Figure 4.4 each level comprises the particular organ that manages the health system management. The CHMT operates from the city level to the lowest village levels. However, at ward and village levels there are community health committees. The Dodoma City Council is there to make sure that members of the public participate effectively in management of the services through the above mentioned organs. To enhance communities understanding and participation on management of health care services, Dodoma City Council employs various advocacy mechanisms. According to the Medical doctor the council conduct different activities of awareness campaigns about malaria prevention, HIV/AIDS testing and tuberculosis as well other STDs infections. The council created the posters and public meetings
to educate women and the rest of community members on the existence of free healthcare services to some special groups like pregnant women.

Another important role played by this council is to coordinate, assess and approve budget of the health department. The medical officer early pointed that everything pertaining to the administration of health matters are set upon by the council of health management team which has to facilitate the process of free health care provision by undertaking four issues like:

*Ensuring effective monitoring and evaluation, undertake budget approval, provide health facilities and medication to hospital in view of supporting pregnant women and finally, prepare weekly report presentation or feedback concerning free health care provision*(Interview, 20.03.2019).

The health secretary also cemented on the issue of health budget approval, supervision and monitoring of different issues in hospitals such as the way health services are rendered by medical officers, observe and receive report on shortage or absence of different health facilities and she went further to explain that;

*Taking an example of my office as a health secretary, I am supposed to intervene and make follow-up on how pregnant women are treated, identify gaps that arise from the services provided in particular for pregnant women in the lower health centers*(Interview, 17.03.2019).

Refereeing to the what is informed by the key informants about the facilitation of pregnant women in access to free health care services by the local government, the study revealed that the major interventions include health budget approval, identification of gap related to service delivery, prepare and present weekly report, identify shortages occurred on health facilities and make follow on medical officer on the way they treat pregnant women.

Among other things the National Health policy of 2007 and the National health Strategic plan provides directives that emphasis on free access to Antenatal Care services for pregnant Women. According to the Strategic plan of 2008-2015 a pregnant woman is supposed to have made at least four or more ANC visits (URT, 2008). During the ANC visits pregnant women are exposed to a number of
diagnostic services like hemoglobin estimation, blood pressure, urine analysis, tetanus Toxoid vaccination. The national guideline directs that pregnant woman should undertake her first visit during the first trimester of pregnancy (URT, 2007).

4.3.3 Procedures used to access free healthcare service in Dodoma city council

The existing Council guidelines stipulate the procedures for the pregnant women to access free health care services in Dodoma City. Basing on the words of the key informants from the health secretary the starting point for a pregnant woman to get free health care services is to undertake clinical consultations, check for pregnancy test, and then seeks to receive the clinic card. In short he expressed that;

*The producers are directed by ministry of local government and health officers are making follow-up that we attend to pregnant women without charging them after they have been proved to have conceived and she possess a card for the clinic (Interview,19.03.2019).*

The qualitative findings from key informants were also supported by the level of awareness possessed by respondents who took part in filling the questionnaires. The study found that most pregnant women are aware of the procedures for accessing free health care. According to Table 4.3, 97(86%) of respondents were aware of the procedures to access healthcare services. About 94(84%) of respondents explained that procedures to follow to access free healthcare services include medical consultations, test for pregnancy and obtain the clinical cards.
Table 4.3 Availability on the procedures for accessing the free health care services by pregnant women

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scale of responses</th>
<th>Pregnant women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of the process that should be followed for you to access free health care services?</td>
<td>Yes</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>112</td>
</tr>
<tr>
<td>What procedures do you follow to free healthcare services?</td>
<td>Consulting medical doctors, undertake pregnancy test and seek for the reception of clinical cards</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>I don’t know</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field data (2019)

In that regard the study contends that there exist clear procedures which are derived from the PMO-RLGA that access pregnant women with benefits to attend health services free of charge. Another important finding was that majority of women are clearly informed of the basic procedures to follow during pregnancy for them to get access to free health care services in the public health centers.

4.4 The quality of health care services provided to pregnant women in Dodoma city

The second objective of the study was to assess the quality of health care services delivered to pregnant women in Dodoma City. To get insights about this objective, interviews were first conducted to the key informants. Documentary review was also use to understand the criteria for quality measurement as indicated in supervision checklist of Dodoma City Council. The document is appended in the appendix (I) section. The supervision checklist provide the following criteria in the measurement of health facility quality: Availability of medical diagnostic services, Availability of curative and preventive medicine, Community and reproductive health services, presence and application circular and health guidelines. Findings showed that the quality of the health care services provided to pregnant women in Dodoma City is good. The study found that there are different factors that make the quality of health care services to pregnant women to be good. Among them are availability of medical
test and diagnosis, Presence of medicines necessary for curative and preventive treatment and the promptness of services providers like nurse and doctors.

4.4.1 Availability of medical and clinical services for pregnant women

The health secretary affirmed that pregnant women who attend services in the public centers are availed with lots of health services. She said that among other services provided in the dispensaries and health centers include:

Antenatal cares, vaccinations, diagnostic examination of communicable and venereal diseases like malaria, gonorrhea, tuberculosis, HIV test, and others. Also, the expectant mothers are tested for the blood content and are provided with compliments for boosting blood cell reproduction (Interview, 25.03.2019).

The nurse matron of pregnant women further added that in the public health centers pregnant women are also educated on nutrition and balanced diet on how to prepare and consume for the best growth of the mother and child. The narrative findings affirms that there are four major services that are granted freely in the health centers like medications, sensitisation, clinical follow-up for the unborn child and labor or delivery services.

The descriptive results from the visited health centers and dispensaries also portrayed that respondents are informed about the provision of free healthcare services. The cross tabulated results are presented in Table 4.4 to get insight into the interaction of the awareness and kinds of services availed to pregnant women.
Table 4.4: Available health services in public healthcare centers

<table>
<thead>
<tr>
<th>What kinds of health services do you get free of charge as pregnant woman?</th>
<th>Are you aware that pregnant women are supposed to get free health care services?</th>
<th>Do you know the kinds of health services delivered free for you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Medication including (tablets, Vaccinations and diagnosis)</td>
<td>55</td>
<td>3</td>
</tr>
<tr>
<td>Sensitisation including (Reproductive and Child Healthcare, Balance diet, cleanness and family planning)</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Unborn child progress</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Labour facilities including dishes, children hats and nets</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>I don’t know</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>108</td>
<td>4</td>
</tr>
</tbody>
</table>

**Source:** Field data (2019)

From the outset of Table 4.4, it was found that respondents are aware of the kinds of services provided from the public health care centers. To mention the services include medication services like provision of tablets, vaccinations and diagnosis, sensitisation on reproductive, child Healthcare, balance diet, cleanness and family planning, attending clinic for follow-up of the unborn child progress and receive labor and post-delivery facilities like dishes, children hats and nets.

### 4.4.2 Presence of medicines necessary for curative and preventive treatment

The doctor in charge of Hombolo health centers informed that pregnant women are availed with different medical services. She attested that:

*Pregnant women receive the prescribed medicines from the health centers and dispensaries”. The Government has decentralised the system of resources flow and that is why medicines are given to pregnant women in the center different from other previous years when the medicine sector was very poor (Interview, 15.03.2019).*

Another clinical doctor from Ihumwa dispensary added that *women get medicines from here after thorough diagnosis and if found with any disease.*
Respondents who took part in filing the questionnaire confirmed the findings from key informants. Figure 4.5 shows that 97% of respondents agreed to receive prescribed medicines from the health centers and dispensary.

**Figure 4.5: Provision of Prescribed Medicines from Health Centers**

Source: Field data (2019)

### 4.4.3 The promptness of services providers like nurse and doctors

Respondent were demanded to give their experiences about their personal observations on responsiveness of service providers in the course of attending health care services in public hospital during pregnancy. As they receive the services free of charge. In different occasions interviewees informed that the pregnant women are part of the priority in the delivery of health services followed by children. One of the health secretaries insisted about her perceived nature of treatment for pregnant women in these words: “I believe pregnant women receive fair treatment from doctors and nurses, though sometimes they report that some nurses are rude during clinic attendance, but such event are rare” (Interview, 22.03.2019).

It was therefore revealed that women get quality and fair treatment from public health institutions. This is due to the fact that doctors and nurses are responsive and respectful to the needs of patients, in particular pregnant women. One of the respondents, the doctor from Makole health center informed in the following words:
In real situation pregnant women are given priority with due respect, and we have insisted that the midwives should not attend pregnant delivery in the streets, instead they should be sent to health centers for safe and free services (Interview, 27.03.2019).

The descriptive responses were summarized in Figure 4.6. The figure suggests a very impressing picture that patients are well treated in the hospital health care centers and dispensaries.

**Figure 4.6: Respondents’ perceived promptness of service providers**

![Bar chart showing perceived promptness of service providers.]

**Source:** Field data (2019)

There is evidence from Figure 4.6 that 80% of respondents the quality of treatment rendered to pregnant women are high in public health institutions. The impressing result denotes that the provision of free health services to pregnant women is well administered and adhered to by medical officer and nurses. In particular respondents agreed by 97% that they received medicines after medical or laboratory tests.

4.4.4 The perceived quality of free healthcare services provided to pregnant women

In attempt to assess the quality of healthcare services provided to pregnant women in the public health centers. Different key informants appreciated the quality of services offered in the health centers and dispensaries. The improved health technology like uses of ultrasound X-Rays and CT Scan though these are not recommended for pregnant women, the best advancement is the improvement in
diagnostic services. The chief doctor in charge of Mkonze Health centers reported said that the diagnostic service has highly improved nowadays than ever since the integration of Information Technology in Laboratory. He further insisted that:

*Without proper diagnostic services there is nothing that we can proud of in provision of health care services, quality diagnosis is the pillar of health service provision since, without which we can hardly manage patients, we cannot prescribe them curative medicines, neither advise the of the preventive measures rather than just guessing (Interview, 29.03.2019).*

Apart from the impressive remarks provided by respondents in the interview results, the medical officer from Mtumba health center further informed that “*the quality is good though they face a problem of shortage of refrigerators for conserving blood*”.

The study inquired from respondents to rank their appreciation level on the quality of health services. Table 4.5 demonstrates that 42(37.5%) of respondents conceived the quality to be moderately impressing, 37(33%) of respondents perceived the quality to be very impressing services, 31(27.7%) of respondents viewed the quality not impressive and 1(1.8%) found the quality very poor.

**Table 4.5: Level of Free Healthcare service Quality**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scale of responses</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you appreciate the health care services delivered freely for you?</td>
<td>Very impressing services</td>
<td>37</td>
<td>33.0</td>
</tr>
<tr>
<td></td>
<td>Moderately impressing services</td>
<td>42</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td>Not impressive services</td>
<td>31</td>
<td>27.7</td>
</tr>
<tr>
<td></td>
<td>Very poor services</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Source:** Field Data (2019)

**4.5 Roles and Influence of Dodoma City Council on management and provision of health care services to pregnant women in the City**

The third specific objective of the study was to assess the roles and influence of Dodoma City Council on management and provision of free health care services to pregnant women in the City. This was explored through interviews with the key informants and by questionnaire method. Despite the fact that Dodoma City Council is the overseer of health services in the city, pregnant women get health services
through various health centers. This being the case, the City Council has power to monitor and influence what health centers do in delivery of health services. Findings from interviews revealed that Dodoma City Council has influence on healthcare services provided in the health centers.

4.5.1 Mandated powers of Dodoma City Council of health management team

The CHMT in Dodoma city has a lot of responsibilities that portray their roles in facilitating the provision of healthcare services in the city. In the same vein the medical officer from Kikuyu Dispensary emphasized that the LGAs play part in the undertaking various responsibilities of supervising and coordinating the provision of health service to pregnant women through a number of activities done in the city. He stated the activities of the Dodoma City as follows:

The LGA through the council of health management team publish brochures which inform about the reproductive health, women health during pregnancy and where to get free health services for the pregnant women and the born child under five years. They also undertake serious supervisions and coordination in hospitals, health centers and dispensaries by establishing different development projects and campaigns against HIV infections, encourage couples to go for HIV tests and live healthy. That is not the end, they also provide training on nutrition to women during pregnancy and after delivery on how to breast feed their babies; ensure health growth of the child, family planning and use of balanced diet (Interview, 10.03.2019).

The Municipal medical officer of health further cemented that generally any role that the CHMT play was focused on different groups of people, but to come to your point of focus on pregnant women, the Dodoma city council has set of specific responsibility as pronounced in its strategic plan.

Among other roles the Dodoma City council is obliged to ensure the provision of free health care services to women in a number of ways like: (i) Information dissemination to community members, (ii) Encouraging women and their partners to visit healthcare centers for diagnosis and advices, (iii) Develop and coordinate health programmes that respond to reproductive health services to youth, women and other special groups (Interview, 23.03.2019).
The study revealed that the local government authority of Dodoma city council was played a number of roles through the coordination, supervision, initiatives to provide training and information on where to get free health services without charges for pregnant women.

4.5.2 The perceived influence of Dodoma LGA in provision of free health care delivery

The researcher probed respondents to tell about the authority of Dodoma city council in performing their roles and duties. The narrative information from the interviewees also affirmed that the LGA in Dodoma city is influential in that it makes efforts to improve the situation regarding the provision of health services in the hospitals and primary health centers and dispensaries.

The council administers the approval of budgets for health facilities and rectifies default observed in the practice of the health care delivery. In short the Health secretary had this to say:

*There is a new practice that is commonly known as direct facility financing. With this approach each health center has the authority to draft its own budget in collaboration of the Health governance board. Each health facility supposed to submit its budget to the council Health Management Team for approval*” (Interview, 26.03.2019).

In addition the doctor in charge of Mkonze health center explained “that the Dodoma City council can demote or promote any health staff basing on its evaluation as weather the person acted wrongly or rightly”. The City medical officer cemented on the influence of the Dodoma city council on management and provision of free healthcare services in the following words:
The central objective of decentralising health system delivery was to enhance the quality of service delivery and improve the management of health service delivery in the local settings. It follows that the central government makes plans, allocate budget and provides some directives, but the local government is the sole implementer of the plan and the budget as mandated by the central governance, so here in Dodoma city has the authority over its jurisdiction to regulate and coordinate the health department to respond to the national policies and guidelines such as provision of free healthcare services (Interview, 20.03.2019).

It follows that the Dodoma City council oversees the activities of the health facilities and has the authority to warn or award any health staff who either misbehave or perform well. This signifies that the Dodoma city council has the influence to enhance the management of health care services to pregnant women.

To measure the influence, the study went further to attest the level of influence of Dodoma city council on managing the provision of free health care services to pregnant women. The likert scale was used to provide the measurement scale from 1= very high influence, 2 =moderately influence, 3=weak influence, and finally, 4=very weak influence as portrayed in Figure 4.7 of the results.

**Figure 4.7: The influence of Dodoma city council provision free health care services**

![Graph showing the influence of Dodoma city council in managing provision of healthcare services to pregnant women]

<table>
<thead>
<tr>
<th>Scale of responses</th>
<th>Very high influence</th>
<th>Moderate influence</th>
<th>Weak influence</th>
<th>Very weak influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>13.0</td>
<td>63.0</td>
<td>17.0</td>
<td>7.0</td>
</tr>
</tbody>
</table>

**Source:** Field Data (2019)
Figure 4.7 shows that the Dodoma city council was perceived to be moderately influential by 63% of respondents; weak influence by 17% of respondents, very highly influential by 13% of respondents and 7% of respondents sought it was very weak in influence. The study contends that the Dodoma LGA has a moderate influence in managing the provision of free health care services to pregnant women.

4.6 Summary of the findings

The chapter presented the findings of the study from the collected data. It began with the description of the social demographic profile of respondents who were pregnant women in one hand and health officials as key informants on the other hand. There were three specific objectives which were analysed and from which the findings were presented.

The first objective assessed the LGA structures and procedures used in the provision of health services. The administrative functions of LGAs were coordination, supervision and monitoring the issues and activities related to health delivery in the city and hospitals or health centers found within their jurisdictions. They are supposed to sit for budget approval, identify gap related to service delivery, prepare and present weekly report, identify shortages occurred on health facilities and make follow-ups on medical officers on the way they treat pregnant women. The study found that the local government authority make use of the council of health management team in the administration of the health delivery in the city council of Dodoma. However, there structures that guide the provision of health services are in three levels, the Community health level, Secondary and tertiary and the central, monitoring and decision making level. The procedures to follow in the provision of free health services for pregnant women were well known by 70% of the respondents. The procedures involved consulting doctors, take pregnancy test, and seek for the clinical card. In brief the local council of health management team has the mandate to represent the LGA body on affairs of health.
The second objective examined about the quality of health care services provided to pregnant women. The study revealed that pregnant women were informed that they are to receive health services with no user charges. The quality of treatment was reported to be moderately impressive by 70%, there was provision of medications, vaccinations, sensitising on reproductive health, hygiene, family planning and other nutritional and balanced diet. Other services provided were, clinical follow-up of the unborn child progress and labor and delivery services. The application of health technology improved the diagnostic services and easy management of patients. The study found that the quality of services was moderately impressive due to promptness of services providers, improved medical diagnostic services and availability of prescribed medicines.

The third objective assessed the roles and influence of Dodoma local government authority in management of free healthcare services for pregnant women. The study found that Dodoma city council played different roles in favor of pregnant women to access health care services. Provide information to community members, encourage partner to visit health facilities for checkups, coordinate training on reproductive health, nutritional foods and hygiene and disease preventions. The study contends that the Dodoma LGA has a moderate influence in managing the provision of free health care services to pregnant women.

This was perceived by 63% of respondents. The key informants supported that the local government authority of Dodoma city council was moderately influential, through the coordination, supervision, pass budgets and oversee on ethical conducts of health officers.
CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

The chapter discusses the findings derived from chapter four of this report. The first section discusses the findings of the first specific objective. The second section provides a discussion of the findings for the second objective. The third section discusses findings of the third specific objective. In short, the first objective assessed the LGA roles, structures and procedures used in the provision of health services. The second objective examined the quality of health care services provided to pregnant women. The third objective assessed the role and influence of Dodoma local government authority in management of free healthcare services for pregnant women. In the course of discussion the background variables presented in the demographic information were integrated to provide facilitate some explanation of the findings. In addition the findings of other studies are brought in the discussion to give a sense of complementarily to the findings of the present study.

5.2 Assessment of LGA structures and procedures used in the provision of health services

The first objective assessed the LGA roles, structures and procedures used in the provision of health services. It assessed the administrative functions of LGA, the structures of LGA in facilitating pregnant women to access free health care services and procedures used to access free health care services for pregnant women.

5.2.1 The administrative functions of LGAs health service provision

The administrative functions of LGAs were coordination, supervision and monitoring the issues and activities related to health delivery in the city and hospitals or health centers found within their jurisdictions. They are supposed to sit for budget approval, identify gap related to service delivery, prepare and present weekly report, identify shortage occurred on health facilities and make follow-ups
on medical officers on the way they treat pregnant women. These findings were in coherence with the theoretical model of decentralisation function at the level of local government offices in line with the provision of services to the public in particular pregnant women. According to Padreep (2011) Decentralisation Model of Service Delivery is based on the subsidiary principle of governance whereby, the services and products to be delivered are devolved to the lowest level of the government. In addition, Jones and Bartelet (2010) proved that healthcare managers in are required to provide leadership services such as coordinate and supervision of employees in the health organisation. Scholars support the findings of the study since the explained results of the respondents related to the conceptual explanation of healthcare management.

5.2.2 Existing structures for LGA in enhancing free healthcare service delivery for pregnant women

The study found that the local government authority make use of the council of health management team in the administration of the health delivery in the city council of Dodoma. The health system is categorized into three levels or structure like community health facility, secondary and tertiary hospitals and centralised policy making and monitoring entity. Different structural levels guidelines and laws are been created to support and ensure health provision in the health facilities from the lower levels to the national levels. The findings of the study were supported by the studies done by Kearns, Hurst, Caglia and Langer (2014) and Shija, Msovela and Mboera (2011).

5.2.3 Procedures pregnant women adhere in the provision of free health services

The procedures to follow in the provision of free health services for pregnant women were well known by70% of the respondents. The procedures involved consulting doctors, take pregnancy test, and seek for the clinical card. However, there was a group of respondents who failed to understand and describe the procedures. It is possible that, the young age expectant mothers like those who belonged to the age
group of 16-25 years were less informed about the procedures. The predominant number of women had basic level of education, that is primary and secondary schools. The low level of education is normally related to low level of information (Mullany et al., 2008), and thus it could be implied that among others, the pregnant women with primary level and with young age were less informed about the procedures to be adhered in accessing free health services. However, there was no study done to elucidate about the procedures to follow for pregnant women intending to access the health care services without user charges.

5.3 The quality of health care services provided to pregnant women

The focus of the second objective was to assess the quality of health care services delivered by the public health institutions to pregnant women. Since the assessment based on the perspective of the user, the study sought first to identify their awareness about the kinds of services that are provided with no user charges. The next was to measure the quality of treatment received by pregnant women, and finally to find out the willingness of respondent to attend free health care services given the financial cost are affordable.

5.3.1 The quality of treatment received in public health centers

It was reported that the treatment of pregnant women was very favorably high by 70%. The quality of services was very impressive by 86%. There are number of studies that have analysed the quality of healthcare services provided to pregnant women (Ngxongo, Sibiya and Gwele, 2016; Nindi, 2015; Oladapo et al., 2008). The study by Ngxongo, Sibiya and Gwele (2016) in South Africa reported that pregnant women were impressed with the quality and nature of services they receive during the antenatal period. The similar experience was reported in Nigeria where by the assessed experience of women during pregnancy was found to be satisfactory with regard to the level of expertise and basic technical competence of their care providers (Oladapo et al., 2008). In contrary, Nindi (2015) found that the quality of services provided to pregnant and children under five years was disgusting at Frelimo hospital in Iringa municipal council. According to her findings the
introduction of expectation policy on user-fees the quality declined progressively. The observations are different to what is seen in the provision of healthcare services in Dodoma city council.

5.3.2 Available healthcare services provided without charges to pregnant women

The study revealed that pregnant women were informed that they are to receive health services with no user charges. There was provision of medications, vaccinations, sensitising on reproductive health, hygiene, family planning and other nutritional and balanced diet. Other services provided were, clinical follow-up of the unborn child progress and labor and delivery services. According to Yabo et al. (2013) the large of women pregnant were informed about the kinds of services offered out of charge in the health centers. These observations are in line with the findings of the present study. However, with reference to the study findings, the social demographic characteristic of respondents in particular regarding to age, and occupation would be a factor for them to be informed about the services provided. The age determined their experience in attending such services during past pregnancies while their occupation status as well entails the level of socialisation with the rest of the society. The occupation status like peasants, entrepreneurs, and other employees in public and private sectors have access to information about kinds of service availed for pregnant mother in the health centers.

The findings of the study get inspiration from the health sector report (2009) which explains the demand of linking primary health service delivery to poor and marginalised groups and the efforts of poverty reduction. It was further evidence that the establishment of free healthcare services and its devolution to the lower government was among the strategy to bring relief to users and rise their life standards (Mboera et al., 2008). It follows that, together with the observed quality, the income status urges users to prefer free to cost sharing services.
5.4 The roles and influence of Dodoma LGA in management of free healthcare services for pregnant women

The third objective assessed the roles and influence of Dodoma local government authority in management of free healthcare services for pregnant women. The study relied on two variables: the level of information dissemination of the LGA and the perceived influence of LGA in Dodoma.

5.4.1 The roles of the LGA free health care service provision to pregnant women

It was found that the Dodoma City council played different roles to impact on the provision of free health care services for pregnant women. Among the roles include information dissemination, provide training services to women and other community members and oversee the health service delivery in the city. The study derives a theoretical support from the decentralisation theory. According to the theory the public services are supposed to be discharged by the lower government in the context of jurisdiction since it has control and knowledge of the geographical area (Fleurke and Hulst, 2006). In addition the local government communicates easily to the local population as compared to the central government (Myasenga, 2017).

5.4.2 The influence of LGA in Dodoma managing free health care service provision

The study discovered that 63% of respondents conceived that the Dodoma LGA has a moderate influence in managing the provision of free health care services to pregnant women. The key informants supported statistical findings in that the authority of Dodoma city council was moderately influential, through the coordination, supervision, and initiatives to provide training on where to get free health services without charges for pregnant women. According to Ahmad et al, (2005) the local government leaders are coordinators and local decision makers who translate the policy declaration of the central government. However, the reported produced by Health Sector Performance Profile Report (2008) enlisted some of the
shortcoming which fails the local government administrators to improve performance among them were financial, and human personnel ability. The findings of the report were in opposition with the present study since the LGA in Dodoma were found to have influence in the services delivery due to their managerial capacity.
CHAPTER SIX

SUMMARY, CONCLUSION AND POLICY IMPLICATIONS

6.1 Introduction

This chapter presents the summary of the study, conclusion, implications and recommendations which emanated from the study. It also provides limitations of the study and suggestions for further research study in relation to the influence of local government authority on provision of free healthcare services to pregnant women.

6.2 Summary of the study

The study is moved by the fact that the provisions of health services among others were developed into local government authority through the decentralisation policy in Tanzania. Similarly, there were some groups of people who gained exemption priority in accessing free health services including the pregnant women. The general experience of the performance of LGAs in many other sectors of service delivery like in education and agriculture were found too challenging.

Probing from the juncture of LGAs and administration of services delivery, the study sought to learn the situation in provision of free health service for pregnant women, what roles and influence does the LGA has? Generally, the study aimed to investigate the role and influence of LAGs in providing free healthcare service to pregnant women in Dodoma city council. The specific objectives were: to assess the LGA health care services roles, structures and procedures for pregnant women; to examine the quality of health care services provided to pregnant women; to assess roles and influence of Dodoma City Council on management and provision of health care services to pregnant women. The study used the interpretive approach and case study design. Using the purposive and convenience sampling techniques the study attained the sample size of 120 respondents. The semi-structured interview, questionnaire as and the documentary review methods of data collection were employed. A content analysis method and descriptive statistical method were used to analyses the collected data.
The findings for the study were as well presented in accordance with the specific objectives. The first objective found that the LGA has administrative functions which include coordination, supervision and monitoring health service delivery between the city council and health centers. The CHMT is the structure which functions at the top level of the LGAs with other health boards and committees. In addition, the CHMT has to approve budget, identify gap related to service delivery, prepare and present weekly report, identify shortages occurred on health facilities and make follow-ups on medical officers on the way they treat pregnant women. Pregnant women had to adhere to the producers like consulting doctors, take pregnancy test, and seek for the clinical card. In brief the local council of health management team has the mandate to represent the LGA body on affairs of health.

The examination of the second objective revealed that four kinds of health care services were provided to pregnant women without charges. They include provision of medications, vaccinations, sensitisation on reproductive health, hygiene, family planning and nutritional diet. Others were following up of unborn child progress and labour services. The quality of service was perceived to be impressive by 70%, due to quality treatment by doctors and nurses and the presence of prescribed medicines after laboratory tests.

The third objective was to assess the roles and influence of Dodoma LGA in management of free health care services. The LGA was found to play notable roles like information dissemination, make plans and pass budgets, implement the health policies declarations and oversee on ethical conducts of health officers and conduct training on reproductive health and nutritional food preparations and encourage HIV testing and camping for preventions. Importantly, the LGA was perceived moderately influential by 63% of respondents.
6.3 Conclusion

Following the presentation of findings and discussion of the study, it could be concluded that the LGAs is moderately influential in administering the provision of free healthcare service for pregnant women. The CHMT played a middle agent role to coordinate the management and administrative function between the central government and the community and stakeholders via the health centers. The CHMT facilitated pregnant women to access free healthcare services in the local government authority of Dodoma city.

The awareness level of expectant mother implied that the LGAs officials and health official adequately play their roles to disseminate information to the intended consumers. There were simple procedures to be adhered to by pregnant women and the good quality of services together encouraged women to prefer attending and use the free maternal services.

The existence of different medical services at the disposal of pregnant women mental that the local government authority administered the process of health care services to pregnant women. Lastly, the information sharing, trainings, coordination and supervision functions were performed fairly to influence the provision of service in health sector.

6.4 Policy Implications of the study

Basing on the findings and conclusion the study develops three policy implications;

The provision of free health services for pregnant women was found to be top-down oriented programme. The decentralisation and devolution of the service was supposed to contain some aspects of bottom-up approaches for the user to have the inclusion in important decisions about the delivered services.

The provision of free health service to pregnant should have precise articulation of kind of services that could not be provided free of charge during pregnancy. The management practices are found to be more evident at the district level whereas the
local government authority begins from the street level. The policy should foresee the possibility of trickling down the information to the lowest level of governance for communication to be more disseminated.

6.5 Recommendations

The study recommends for the programme to continue with several improvements in terms of manpower, technical facilities and infrastructures. The practice of free health care service needs to be improved by focusing on post delivery services to maternal mothers.

The service users were well informed about the free maternal healthcare provision, however, there is need to encourage them to effectively use the services as to support the government in attaining the policy targets.

The providers of health care services like doctors and nurses should be motivated and continue to be more patient and attentive to pregnant women needs and problems as to curb the event of ante and post maternal delivery.

6.6 Limitations of the study and suggestion for further research

The study faced two major limitations in its realisation. The first was the limited number of literatures from Tanzania authors and the second was poor collaboration of the responsible key informants as indicated in the methodology chapter. There is need for conducting other studies focus on the influence of LGAs in health delivery for pregnant women. A study is needed to analyse the administrative challenges facing the local government authority in the management of free health care services for women and other special groups. Another study would be useful to determine determinants of women preference to use free health care services while controlling income factors.
REFERENCES


Maluka, S. (2011) Strengthening Fairness, Transparency and Accountability in the


Mubyanzi, M. (2007) Local Primary Health Care Committees and Community-


APPENDICES

APENDIX I: HALMA'SHAURI YA WILAYA YA DODOMA – IDARA YA AFYA

FOMU YA USIMAMIZI SHIRIKISHI WA HOSPITALI YA WILAYA,
VITUO VYA AFYA NA ZAHANATI

1.0. UTANGULIZI:

Jina la Kituo: ………………. Tarehe ya usimamizi wa mwisho: …………..
Jina la msimamizi Kiongozi: ………………. Kutoka ………………………
Tarehe ya Usimamizi huu: ………….. Muda wa kuwasili ………………
Upimaji huu ulipangwa? - (weka alama ya □) Ndiyo [   ] Hapana [   ]
Ushirikishwaji wa Uongozi wa jamii inayohudumiwa na Kituo - (weka alama ya □)
Wamealikwa siku ya usimamizi Ndiyo [   ] Hapana [   ]
Wamehudhuria kikao cha usimamizi Ndiyo [   ] Hapana [   ]

1.1. KAMATI/BODI YA UENDESHAJI YA KITUO: Ipo na inakutana?
Ndiyo [   ] Hapana [   ]
Mara ya mwisho Kamati hiyo ilikutana lini ? …………………
Muhtasari wa kikao hicho upo? (unapatikana ?)Ndiyo [   ]Hapana [   ]
Kama ndiyo orodhesha dondoo/agenda zilizojadiliwa katika kikao hicho:
(1) …………………………………………………………………………
(2) …………………………………………………………………………
(3) …………………………………………………………………………

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1.2. **KAMATI ZA AFYA ZA VIJIJI/KATA.**
Tarehe za vikao vya Kamati za Afya za vijiji vilivyofanyika katika robo ya mwaka.

<table>
<thead>
<tr>
<th>NA</th>
<th>JINA LA KIJIJI</th>
<th>TAREHE YA KIKAO</th>
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3. **HALI YA HOSPITALI/KITUO CHA AFYA / ZAHANATI:**

3.1. ENEO NA MIPAKA YA KITUO: Je, inajulikana / inatambuliwa? -
Ndiyo [    ] Hapana [    ]

3.1.1. Leseni /Registration Namba ya kituo ..........................................

3.1.2. Organisation structure ipo ubaoni ndio/hapana

3.1.3. Staff Attendance register yenye kuingia na kutoka ipo?.........................

3.1.4. Staff waliopata mafunzo ya MTUHA wapo/wangapi? ............................

3.1.5. Madaftari ya MTUHA yanatumika kikamilifu ndiyo/hapana angalia vitabu vyote vya MTUHA

3.1.6. Takwimu za MTUHA zipo na zinafanyiwa kazi katika kituo ndiyo/hapana

3.1.7. Takwimu za kituo za mwaka jana za kituo zipo Ndiyo/Hapana

3.1.8. Kumbukumbu za wagonjwa na wanapopewa matibabu zinawekwa katika usiri ndiyo/hapana

3.1.9. Opras kwa watumishi inafanyika (onyesha faili la kumbukumbu za opras) Ndiyo/Hapana
3.1.10. Majukumu ya kazi yapo kwa kila mtumishi na yamesainiwa ndiyo/hapana (onyesha faili)

3.1.11. Jina la kituo na masaa ya kazi yameandikwa katika ubao nje yakituuo................

3.1.12. Ratiba ya watumishi walipangwa zamu na nambaza simu zao ipo?.........................

3.1.13. Mpangilio wa huduma na bei zake na msamahamrewekwa katika mbao ya matangazo ndiyo/hapana

3.1.14. Service charter ipo?..........................................................ndiyo/hapana

3.1.15. Mapato,matumizi,bajeti ipo katika mbao ya matangazo? Ndiyo/Hapana

3.1.16. Ratiba ya mobile clinic/outreach ipo? Ndiyo/Hapana

3.1.17. Pana watumishi wana mafunzo ya emergence na acident kwa watoto na watu wazima? Ndiyo/hapana

3.1.18. Dawa vifaa vya emergence vipo......................................... ndiyo/hapana

na ni vipi Vitaje:-.................................................................

3.1.19. Rufaa ya wagonjwa inachukua muda gani wa rufaa za wagonjwa kutoka vituoni mpaka hospitali ya Wilaya........................... mshindo nyuma upo baada ya rufaa

ndiyo/hapana

3.1.20. Wagonjwa kuridhika na huduma ya kituo chagua/pitia/dodosa wagonjwa watano.......... 

1. Walioridhika wangapi ..........................maelezo yao/kwa kipi..........................

2. Wasioridhika wangapi..........................maelezo yao/kwa kipi..........................

3.1.21. PPM imefundishwa kwa staff ndiyo/hapana
3.1.22. PPM imepangiwa bajeti/inatekelezwa katika kituo Ndiyo/Hapana kama ndiyo ni shilingi ngapi

3.1.23. Vyoo vya kituo viko salama kwa watu ambao ni walemavu? Ndiyo/hapana

3.1. 24. Essential equipment and furniture vipo kila chumba kituoni angalia chumba baada ya chumba

3.1.25. Essential medicine (tracer medicine) je zipo na ni zipi?.........................

3.1.26. Utunzaji wa vifaa na dawa angalia zinapotunzwa andika ulichoona.....

.................................................................................................................................

3.2. HUDUMA ZA MAJI/UMEME KIJIJINI NA KITUONI.

- Idadi ya Visima virefu (Mashine ya Injini, mashine ya upepo) ....................

- Idadi ya Visima vifupi (vya kupampu kwa mkono) ............................

- Je, kuna vyanzo vingine vya maji? (taja chanzo na idadi): .........................

- Je kituo kina umeme/solar power.............
3.3. MAZINGIRA YA KITUO / ZAHANATI.

Jedwali la 2: (weka alama ya □)

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<th>Hakuna</th>
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<td>Usaﬁ wa vyumba</td>
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<td>Vitenganishi taka [IPC]</td>
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<td>Kidogo:</td>
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<td>Uimara wa jengo</td>
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<td>Vyumba vina hewa ya kutosha</td>
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<td>Vyumba vina siri kwa wagonjwa</td>
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<td>Huduma ya kunawa mikono ipo kila sehemu</td>
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</table>

10. UPATIKANAJI NA UTUMIAJI WA VITABU MBALIMBALI VYA MIONGOZO

- Je, vitabu vya Miongozo vifuatavyo vipo (SOP)? - Malaria [ ] – BEmONC/CEmONC [ ] - Life Saving Skills [ ] HIV/AIDS [ ] - TB/Leprosy [ ] - Afya ya Akili [ ] - NACS [ ] Vingine…………………………

- Je, Miongozo ifuatayo imebandikwa? - HIV Testing Argorithm [ ] - Utayarishaji wa JIK [ ]

Matumizi ya Magnesium Sulphate [ ] - mingine (taja) …………………
**UPATIKANAJI WA HUDUMA ZA MAABARA**

Angalau kuwe na kuwe na kifaa kimojawapo

1. Darubini inayo fanya kazi  
   
   Glass slide  
   
   Field stain A & B  
   
   Yes  No

2. Usajili sahihi wa wagonjwa 
   Yes  No

3. Maabara ni safi  
   Yes  No

4. Mabomba ya sindano yapo  
   Yes  No

5. Vifaa vilivyopo vimetakaswa (sterile)  
   Yes  No

6. Kinyesi kinapimwa kikiwa fresh  
   Yes  No

7. Je watumishi wa maabara wanavaa mipira ya mikono (gloves)  
   Yes  No

8. Kuna makoti ya maabara  
   Yes  No

Maabara inaweza kufanya vipimo vifuatavyo?

- Kupima malaria  
  Yes  No

- Kupima damu  
  Yes  No

- Gram stain  
  Yes  No

- RPR  
  Yes  No

- Kumpimamama kama anaujauzito (Pregnant test)  
  Yes  No

- Kupima Ukimwi (HIV rapid test)  
  Yes  No
11. TAARIFA YA UTENDAJI YA ROBO YA ........... (Mwezi ................. hadi ................. Mwaka 20.......

Jedwali la 6:

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<td>- Mahudhurio ya marudio</td>
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<td>- Watoto wenyewe ukondefu kiasi (60-80%)</td>
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<td>- Watoto wenyewe udumavu mkali (&lt;60%)</td>
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<td>- Wagonjwa wa nje waliotibiwa - (OPD)</td>
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<td>- Wagonjwa waliolazwa (In – Patients)</td>
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<td>- Wagonjwa waliokolosha kwenda Hospitali</td>
<td>(Kwa gari la wagonjwa)</td>
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12. UPATIKANAJI WA DAWA ZA TIBA, CHANJO NA GESI:

i) Je dawa za tiba zipo za kutosha? Ndiyo [ ] Kiasi [ ] Hakuna [ ]

ii) Je dawa za chanjo zipo za kutosha? Ndiyo [ ] Kiasi [ ] Hakuna [ ]

iii) Je gesi ipo ya kutosha? ..................... Ndiyo [ ] Kiasi [ ] Hakuna [ ]
iv) Je, chanjo zimepangwa ipasavyo? Ndiyo [ ] Hapana [ ]

v) Hali ya ubaridi wa jokofu wakati wa usimamizi huu ni nyuzi joto ............

13. Hali ya Mapato na Matumizi ya Fedha za Papo kwa Papo, MFuko wa CHF, KfW, NSSF na NHIF.

i) Mapato ya fedha za papo kwa papo kwa kipindi cha miezi .......... ni Tshs ........................................

ii) Kiasi kilichopelekwa Benki ni Tshs ............................................. Risiti Na: .............................................

iii) Jumla ya Wanachama wote hai wa CHF kwa kipindi cha robo mwaka ..........................................................

iv) Jumla ya Wanachama wote hai wa KfW kwa kipindi cha robo mwaka ..........................................................

v) Mapato ya mfuko wa CHF kwa kipindi cha miezi ........ ni Tshs ..........................................................

vi) Kiasi kilichowasilishwa Halmashauri ni Tshs ........................................ Risiti Na: ........................

vii) Kiasi cha fedha kilichotumika kwa kipindi cha robo mwaka ..........................................................

viii) Ujazaji wa fomu za NHIF na NSSF ..........................................................

ix) Mapato ya Mfuko wa Taifa wa Bima ya Afya....................................................

x) Mapato ya NSSF(Hospitali ya Wilaya)...........................................................
14. HUDUMA SHIRIKISHI JAMII ZA AFYA YA UZAZI NA MTOTO:

i) Wakunga wa jadi wangapi waliwasindikiza wajawazito kujifungulia katika Kituo cha huduma? ………………..

ii) Akina baba wangapi wameshirikishwa katika huduma ya Afya ya uzazi na mtoto? ………………..

iii) Vifo vya wazazi na watoto wachanga vilivyotokea katika ngazi ya jamii:

(Kikao na viongozi wa Kijiji au Kamati ya Uendeshaji ya Kituo)

- Je, kuna kifo chochote cha mzazi / mtoto mchanga kimetokea katika jamii ?
  – Ndiyo [ ] Hapana [ ]

- Sababu ya kifo hicho ilikuwa nini ? …………………………………

- Je, kilikuwa kinaweza kuzuilika ? - Ndiyo [ ] Hapana [ ]

- Je, nini kifanyike siku zijazo ili kuzuia vifo vya namna hiyo ?
  ………………..
APENDIX 11: Interview for CMO, Health secretary, Hospital medical officer in charge of pregnant women

1. Please present yourself. Probe experience, position.

2. What do you have tell about the functions of local government in service delivery?

3. What are the structures of LGAs respond to health care service delivery?

4. How do the structures facilitate the provision of free health care services to pregnant women in your city?

5. What processes are set by LGAs to ensure free health care provision for pregnant women?

6. What healthcare services are offered free to pregnant women?

7. How is your position facilitates the grant of free health care services to pregnant women?

8. How is quality of the service delivered to pregnant women?

9. Do you think the LGAS has influence on HCS provision to pregnant women? How?

10. How does LGAs management influence the HCS delivery?
APENDIX III: QUESTIONNAIRES FOR PREGNANT WOMEN

I appreciate your availability to participate in this research. The study investigates about the “Influence of Local Government Authorities in Management of Decentralised Health Care Services: The Case of Dodoma City Council”. I encourage you to be free to provide the answers from the best of your knowledge. I assure you that the information you give will be treated confidentially with lots of respect. The information to be collected will be used for research purposes only. Please fill in the correct answers.

Personal Details

1. What is your age? ___________________

2. What is your highest education qualification? _______________

3. What is your current occupation_____________________?

4. How do you range your income per month?
   
   i. Below 400,000 Tsh
   
   ii. 400,000-800,000Tsh
   
   iii. 800,000-1,200,000Tsh
   
   iv. 1,200,000-1,600,000Tsh
   
   v. Above 1,600,000Tsh
Part two: Effectiveness of the structures and process for health care services provisions to pregnant women

<table>
<thead>
<tr>
<th>No</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>5</td>
<td>Are you aware that pregnant women are supposed to get free health care services?</td>
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<tr>
<td>6</td>
<td>Do you know the kinds of health services delivered free for you?</td>
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<td>7</td>
<td>Are you aware of the process that should be followed for you to access free health care services?</td>
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<tr>
<td>8</td>
<td>Do you know the health centers which you can access free health care services?</td>
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<tr>
<td>9</td>
<td>Do you think your local government leaders can help you to get free health care services?</td>
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<td>10</td>
<td>I get all health services and treatment free in the health centers</td>
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5. Do you think that free health care services are supportive to your health?

11. What kinds of health services do you get free of charge as pregnant woman?

(a) ........................................ (b) ........................................

c) ........................................ d) ........................................

e) ........................................ f) ........................................

12. From where do you get free health services?

(a) Public health centers/hospital ( ) (b) Private health centers/hospitals ( )

13. What processes should you follow to access free health care services as pregnant woman?

a) ..............................................................................................................................

b) ..............................................................................................................................

c) ..............................................................................................................................

d) ..............................................................................................................................

e) ..............................................................................................................................

f) ..............................................................................................................................
14. Who informed you that you have the right to get free health services in pregnancy?

……………………………………………………………………………………
……………………………………………………………………………………

Part three: Effectiveness of the quality of health care services provided

15. How helpful are your local government leaders in facilitating you to get free health care services

   (a) Very helpful ( )       (b) helpful ( )
   c) Somehow helpful ( )    d) Not helpful at all ( )

16. How do you appreciate the health care services delivered freely for you?

   (a) Excellent quality ( )   (b) Very good quality ( )
   c) Satisfactory ( )        d) poor quality ( )

17. Are nurses treating you fairly?

   (a) Yes ( )           (b) No ( )

18. During consultations, do the doctors take treat you with care and respect?

   (a) Yes ( )           (b) No ( )

19. Do you get medicines free for medications after diagnoses?

   (a) Yes ( )           (b) No ( )

20. Do you think that free health care services are supportive to your health?

   (a) Yes ( )           (b) No ( )
21. If you would have enough money will you still wish to get health services that are delivered freely in the public health institutions?

(a) Yes ( )  (b) No ( )

22. From where do you receive any information about free health care services for pregnant women? ............................................................

23. Do you think that the free health care services you get are due to the influence of the Dodoma city council?

(a) Yes ( )  (b) No ( )

24. Have ever got any difficulties in accessing free health care services?

(a) Yes ( )  (b) No ( )

25. What difficulties do you face in accessing free health care services as a pregnant woman?

a) ..........................................................  
b) ..........................................................

c) ..........................................................

d) ..........................................................

e) ..........................................................

26. Who helped to resolve the problem? ........................................

27. How do you rank the influence of LGA in Dodoma in governing the provision of free health care services for pregnant women

(a) Very high influence ( )
(b) Considerably high influence ( )
(c) Moderate influence ( )
(d) Weak influence ( )
(e) Very weak influence ( )

THANK YOU FOR YOUR PARTICIPATION