DOWNWARD ACCOUNTABILITY IN PUBLIC HEALTH CARE SYSTEM: THE CASE OF TEMEKE MUNICIPAL COUNCIL, DAR ES SALAAM

BY

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A dissertation submitted in (Partial) Fulfillment of the Requirements for the Degree of Master of Public Health of Muhimbili University of Health and Allied Sciences

Muhimbili University of Health and Allied Sciences

November, 2009

CERTIFICATION

The undersigned certify that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled ***Downward accountability in public health care: The case of Temeke Municipal Council in Tanzania, Dar es Salaam,*** in (partial) fulfillment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences, Dar es Salaam.

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DATE 13th NOVEMBER, 2009

DECLARATION

AND

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I, **Irenei Boniphace Kiria,** declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

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ACKNOWLEDGEMENT

I am grateful to all academic staff of the SPHSS (MUHAS), for facilitating transfer of knowledge and skills to me. I am particularly grateful to my research supervisor Dr. M. A. Mwangu. He was particularly understanding and patient even when my ideas kept changing along the way. I appreciate the trust and autonomy he accorded me throughout my research which challenged me to try my best.

I would like to thank my employer, Youth Action Volunteers (now under a new name SIKIKA) for offering me the permission and resources to pursue this degree. I am particularly indebted to my fellow staff for filling the gap I created by attending this degree while working. Particular thanks to Edward Furaha our Senior Programme Officer for his encouragement, inputs to my proposal, and creating space for me in the organization to concurrently manage my work and studies.

I am indebted to Maggie Bangser, my friend, for reading my research proposal at odd hours of the night and providing constructive comments. I understand she once read my proposal at night when there was disturbing loud music from the Leader's Club.

I am grateful to my fellow classmates for the brother/sisterhood, entertaining jokes which motivated me to attend class even when my energy was low or when I had equally important office issues to attend to. I thank them for their tolerance whenever I asked too many questions during lecture hours even when they were already tired and hungry.

Finally, a profound appreciation to my wife Jacqueline and to my precious daughters Lulu and Rubi. They have tolerated me both for my absence and my inaccessibility even when in the house. Particular thanks to my nine-year old Lulu for her motivational jokes. *"Umefundishwa nini shule leo? Leo huendi shule? Hatutaki baba anayefeli nyumbani kwetu?* And to my two years old Rubi for constant big smile and forcing time for me to play with her, who were necessary breaks away from my sometimes long hours of studying.

DEDICATION

This work is dedicated to all Tanzanians who are struggling for quality health care services and good governance of public resources.

ABSTRACT

Accountability in health care delivery is important for three major reasons. First, accountability mediates between citizens and their government on issues of cost, access, quality, and distribution of health care services. Second, because health care providers have been accorded significant powers over people's lives and well-being, accountability will seek to regulate this power for any possible abuses. Third, health care constitutes a major budgetary expenditure (about 11% of total government spending in Tanzania), hence accountability will seek to ensure its proper management, reduce corruption, and increase responsiveness of health care providers and political leaders to citizens.

The main aim of the research was to assess downward accountability of public health care using the example of Temeke Municipal Council. Downward simply means accountability to health service users as opposed to district headquarters and central government.

A Cross sectional study using both quantitative and qualitative methods was undertaken in Temeke Municipality. A total of 432 semi-structured questionnaires were administered to 432 individuals at household level, three in-depth interviews were conducted, and publicly posted information on 24 public health facilities was observed. Analysis of policy and legislative documents was also done.

The public health care system of Temeke municipality is perceived to be transparent and answerable to citizens at 31% and 34% average scores respectively. Citizens with at least form four secondary schooling and those who participate in public health facility planning, budgeting and monitoring are more likely to perceive the health care system as transparent. Citizens who know how to lodge complaints against unsatisfactory health cares services, spend less time waiting to be served and are satisfied with the kind of treatment given are more likely to find the public health care system answerable.

Although policies and laws of Tanzania are generally supportive, downward accountability of public health care system in Temeke Municipal Council is still a major challenge. Public health facilities need to be more transparent and answerable to realize quality health care and citizens' rights.

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LIST OF ABREVIATIONS

ARI:	Acute Respiratory Infections
CAG:	Controller and Auditor General
CCHP:	Council Comprehensive Health Plan
CCHPG:	Council Comprehensive Health Planning Guidelines
DANIDA:	Danish International Development Agency
DSM:	Dar es Salaam
HSSP:	Health Sector Strategic Plan
LGCDG:	Local Government Capital Development Grant
LGRP:	Local Government Reform Programme
Ltd:	Limited
MoHSW:	Ministry of Health and Social Welfare
NAO:	National Audit Office
NSGRP:	National Strategy for Growth and Reduction of Poverty
O & OD:	Opportunities and Obstacles to Development
OPD:	Out Patient Department
PlanRep:	Planning and Reporting Guidelines
PMORALG:	Prime Minister's Office Regional Administration and Local Government
SNV:	Netherlands Development Organization
SPSS:	Statistical Package for Social Science
URT:	United Republic of Tanzania
YAV:	Youth Action Volunteers

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

Since independence in 1961, diseases have remained one of the great enemies of Tanzania along with poverty and ignorance. In the fight against these enemies, the government of Tanzania, guided by socialist policies, offered universal free health services between the late 1960s and early 1980s. In the mid 1980s onwards, the country launched structural reforms shifting from the state owned to liberal economy in order to redress the ailing economy. The structural reforms went hand in hand with the introduction of cost sharing and private enterprise in the health sector replacing the free health service provision by the state. User fees were introduced in public hospitals following the Bamako Initiative in 1987. The logic behind the introduction of cost sharing through user fees was to complement public health budgets following economic crises that incapacitated the state as the sole provider of services.

In its efforts to ensure quality health and wellbeing of the society for personal and country development, the government through the Ministry of Health has implemented many short and long-term plans. The National Health Policy of 2007 succeeded those of 1990 and 2003. The first Health Sector Strategic Plan (HSSP) in Tanzania was implemented from1999-2002. The HSSPII which started in June 2003 came to an end in June 2009 and a third one for the period July 2009–June 2015 has already been

approved. The Primary Health Sector Development Programme 2007–2017 is also under implementation to accelerate primary health care for all.

These policies and strategic plans are incorporated in the National Strategy for Growth and Reduction of Poverty (NSGRP). The NSGRP (2005–2010) is organized around three outcome clusters, namely growth and reduction of income poverty, improved quality of life and social well-being, and good governance and accountability (URT, 2005c). According to the NSGRP (2005), good governance and accountability are pre-requisites for the achievement of broad based growth and improvement of quality of life and social well-being, which is at the same time the thrust chosen for this study.

Reforms are necessary to accelerate good governance and accountability. The Local Government Reform Programme (LGRP) started in 2000 to facilitate decentralization of political, financial, and administrative powers to local governments and change central and local government relations (URT, 1998). The Programme implements legislation geared to devolve power to the local government and increase their autonomy.

Responding to the general reforms, the Ministry of Health introduced reforms which resulted in decentralization of power to local government authorities for delivery of services and management of resources in order to bring quality health services closer to the people and respond to their needs. As a result, Health Boards, Health Facilities Committees and new formula-based fiscal allocation to councils have been introduced to

enhance good governance and accountability in the delivery of health care services at district level.

It is in the context of this background that this study was conceptualized and carried out in Temeke Municipal Council as a case study of downward accountability of public health care in Tanzania.

1.2 STATEMENT OF THE PROBLEM

The government implements local government reforms, among other reasons, to improve the quality of public services, good governance and accountability at district level. With decentralization by devolving more powers and financial resource to the district authorities, health service providers should make better use of public resources while citizens should play their civic role of holding service providers to account in case of any misuse or abuse of public office or resources.

Studies have broadly documented lack of citizen participation and poor access to information regarding public service plans, budget and expenditures (Mamdani and Bangser, 2004). Other studies have documented possible misuse and abuse of public resources, corruption, unfriendly attitudes of health workers in public health care facilities, government service providers and governing committees unaccountable to citizens, and perceived low quality of services. However, how all these issues impact on the overall accountability of public health care to citizens is inadequately documented.

The purpose of this study, therefore, was to assess whether or not the public health care system in Temeke Municipal Council is accountable to citizens by studying its degree of transparency and answerability. Variables such as access to information, people's satisfaction with quality of health care services, perceptions regarding attitudes of health workers, citizen participation in health care planning, practices of bribery in health care services, and existence of complaints against unsatisfactory health care services were assessed.

1.3 RATIONALE FOR THE STUDY

Every year the government of Tanzania spends about 11 percent of its overall budget on health. About 40 percent of the health sector budget is managed directly at the district level for the delivery of healthcare services. The health sector budget is never enough to provide for equitable and quality health care. Proper management of the meager annual district health budget is essential for efficient, effective, and equitable health care delivery.

The on-going implementation of decentralization by devolution aims at empowering citizens to improve service quality through increased citizen participation and improved accountability. Article 27 of the Constitution of the United Republic of Tanzania empowers citizens to safeguard public resources and fight all forms of abuses and misuses of public resources (URT, 2005a).

Information is power! Making finances, plans, and implementation reports available to citizens in various forms can facilitate implementation of Article 27 of the Constitution of the United Republic of Tanzania. For this reason, Article 18 of the Constitution of the United Republic of Tanzania empowers citizens to demand and be supplied with information without any restriction (URT, 2005a). This will contribute to civic capabilities of citizens to effect quality of health services and hold service providers accountable in order to achieve the following objective of the National Health Policy:

> *Kuwa na mfumo madhubuti, mipango na usimamizi shirikishi na endelevu katika sekta ya afya pamoja na watoa huduma ili kuwa na uwazi, matumizi bora ya raslimali na kuhakiki viwango vya huduma zinazotolewa (URT, 2007h:55).*

(Translation: Establishment of participatory, transparent and sustainable system of coordinating all stakeholders in the heath sector in order to improve transparency, rational use of resources and adherence to minimum standards).

Policies and legislation as well as the organization of public health care system are generally uniform for all Councils in Tanzania. Planning, sources of funding and expenditure management are also the same throughout local government authorities in Tanzania. Temeke Municipality is therefore chosen as case study for the downward accountability of public health care system in Tanzania. Findings from this study may be used to inform policy makers, health service providers, and service users alike on the status and nature of transparency and answerability of public health care systems in

Tanzania. Interventions to improve downward accountability of the system may also be informed by these findings.

1.5 GENERAL OBJECTIVE

To assess downward accountability of the public health care system of Temeke Municipal Council

1.5.1 Specific objectives

1. To assess the extent of flow of information[1] from the public health facilities to citizens in Temeke Municipal Council.
2. To determine proportions of citizens perceiving the public health care system of Temeke Municipal Council to be answerable to service users
3. To empirically estimate associations and effects of the determinants of transparency and answerability of the public health care system in Temeke Municipal Council
4. To examine the extent to which existing policy and legislations either promote or hinder accountability of district health departments to citizens.

[1] Information regarding the delivery of government health services, such as annual health facility plan, budgets, revenues, budget expenditure reports, and activity implementation reports.

1.5.2 Research Questions

5. ***Specific Objective 1:*** To assess the extent of flow of information from the public health facilities to citizens in Temeke Municipal Council.

    a. What proportions of health facilities have public notice boards?
    b. What proportions of health facilities posted information about their annual plans, budget and expenditure reports of government health services?
    c. What proportions of health facilities posted information publicly regarding their performance against annual/quarterly targets? Availability of different health care services? Availability of service providers?
    d. What proportion of citizens was aware of information posted publicly at public health facilities?
    e. What proportion of citizens found this information to be user-friendly?[2]
    f. What are citizens' perceived reasons affecting demand and supply of information related to health service delivery at sub-council level?

6. ***Specific Objective 2:*** To determine proportions of people perceiving the public health care system of the Temeke Municipal Council is answerable to citizens
    a. What proportion of the population was aware of the existence and roles of Municipal Health Board and Facility Governing Committees?

[2] They are able to understand and use it

b. What proportion of citizens ever demanded information from service providers on plans, finances and performance of health facilities? How? Why?

c. What proportion of citizens have ever participated/been consulted in the planning, budgeting, implementation and reporting of government health service delivery?

d. What proportion of the population was aware of how to lodge complaints regarding unsatisfactory government health services? How?

e. What proportion of the population ever expressed dissatisfaction with government health services? How? What steps were taken?

f. What proportion of the population was aware of health service user's rights, as per the Client Service Charter of the Ministry of Health and Social Welfare?

g. Perceptions on the existence of corruption in public health care in Temeke Municipal Council.

h. Perceptions on the attitude of health workers to patients.

i. Proportion of population satisfied with quality of public health care in Temeke Municipal Council.

Specific Objective 3: To empirically estimate associations and effects of the determinants of transparency and answerability of the public health care system in Temeke Municipal Council

a. Is there any association between each independent variable with its corresponding dependent variable?
b. Are there any associations between a dependent variable and all its explanatory variables jointly?
c. What is the magnitude of the effects?

Specific Objective 4: To determine the extent to which existing policy and legislations either promote or hinder accountability of district health departments to citizens. The following research questions will guide the analysis:

a. Do the existing policies promote transparency and answerability of public health care system downward to citizens or upward to the central government?
b. Do the existing policies and laws provide for the right to citizens to participate in public health care planning and performance monitoring?
c. Do existing policies and laws impose legal responsibility on health providers and political leaders to provide explanations and justifications to citizens regarding their actions?

1.4 Accountability Conceptual Framework

Interpretation of the conceptual framework

Laws and policies are expected to provide a framework for transparent planning, implementation, and monitoring of district public health care. They are also supposed to provide a framework for service providers to be answerable to service users, and at the same time empower citizens to hold the public health care system accountable. Accountability is expected if all the four conditions apply efficiently and effectively, hence this is what this research undertook to find out.

2.0 LITERATURE REVIEW

2.1 The concept of accountability

Accountability has become a major issue in public health policy and care worldwide, as a necessary means towards achieving quality and equitable health care services. Accountability intends to improve performance of health care providers, management of public finances, and democracy in the delivery of public health care (Brinkerhoff, 2004). Accountability is defined by Allan (2007) as follows;

> *Accountability is the right to obtain justifications and explanations for:*
> *-the use of public resources from those entrusted with the responsibility for their management, whether government officials or private service providers and,*
> *-the performance of officials and service providers in progressively realizing the human rights of those they serve*
> *Conversely, officials and service providers have a duty to:*
> *-provide justifications regarding their performance and,*
> *-take corrective action in instances where public resources have not been used effectively to realize human rights and capabilities (Allan, 2007:3).*

Accountability in health care delivery is important for three major reasons (Brinkerhoff, 2004). First, accountability will mediate between citizens and their government on issues of cost, access, quality, and distribution of health care services. Second, because health care providers have been accorded significant powers over people's lives and well-being, accountability will seek to regulate this power for any possible abuses. Third, health care constitutes a major budgetary expenditure, hence accountability will seek to ensure its

proper management, reduce corruption, and increase responsiveness of health care providers and policy makers to citizens.

For the purpose of this research, the concept of transparency and answerability will be used as measures of accountability. Transparency exists when much is known by service users about plans, finances and performance of health facilities. Answerability on the other hand, is the degree to which health care services are satisfactory to service users.

2.2 Local Government and Health Sector Reforms

The 1982 Local Government Authorities Act (revised in 2000) provided by the article 146 (1) of the Constitution of the United Republic of Tanzania intends to transfer authority and resources to people at the lower level of government in order to give them wider opportunities to participate in planning, implementation and evaluation of development projects within their respective areas (URT, 2005a). Implementation of these reforms is guided by the Local Government Reform Programme (LGRP) which started in 1996 to speed up, among other things, political, financial, and administrative accountability at district level. The program also sought to improve transparency in local government transactions and bring public services down to the people (URT, 1998).

While there are some achievements to date, the central government continues to have control over taxes, financial allocations and expenditures, and civil servant employment, conditions which are necessary for the autonomy of local government authorities and

ability to exercise control and oversight (Braathen et al, 2005). In spite of extensive programmes to implement local government reforms since 1996, only 47 percent of citizens have heard about Local Government Reforms (Fjeldstad and Nygaard, 2003).

Responding to these general reforms, the Ministry of Health and Social Welfare (MoHSW) introduced health sector reforms which resulted to decentralization of power to local government authorities for delivery and management of services. The overall purpose of the Health Sector Reform in Tanzania is to provide accessible, good quality, and cost effective district health services, organized at a decentralized level (URT, 1998). The Local Government Reforms and Health sector Reform Programs both open up the opportunities for people to participate in the design, planning, implementation and monitoring of health delivery and resources at district level. If this is attained, it will lead to health services that better respond to people's health needs.

With the health sector reforms, Health Boards, Health facilities committees and new formula based fiscal allocation to councils have been established in order to enhance, among other things, good governance and community ownership in the public health care systems at local levels (URT, 2001 and URT, 2007j). Under these reforms the local authorities have been given mandate to engage directly in the decision-making processes. Reflecting the need of each district, the Comprehensive Council Health Plans are usually formulated and the resources are directly channeled to the district local authorities (URT, 2007j).

However, citizen representation bodies such as Health Committees and Boards are unknown to ordinary people and are not functioning to the extent planned and wished

(Masuma and Maggie, 2004). This is due to selection of members being done by the government, limited knowledge of their roles, being accountable to the government rather than to the communities they purport to represent, and lack of mechanisms for citizens to hold them to account (Boon, 2007).

2.3 Planning and Reporting

Following the implementation of all these reforms, multiple planning, budgeting, and reporting systems such as Planning and Reporting (PlanRep), Opportunities and Obstacles to Development (O&OD), Council Comprehensive Health Planning Guidelines (CCHPG), and other specific donor funded project planning and reporting guidelines have also been introduced. However, these planning and reporting systems place a lot of pressure on the already limited capacity of the councils. As a consequence, planning at the district level has become an indication of what the district officers think the grass root communities need, while community participation is done on an ad hoc basis leading to poor ownership of both the process and outcomes (Cooksey and Kikula, 2005).

The over all responsibility for development of annual CCHP lies in the Council Health Management Team under the oversight from the Social Services Committee of the Council. District health planning is expected to be done through a combination of PlanRep, O&OD and CCHPG. However, PlanRep and O&OD are not fully compatible with CCHPG and it is not clear when to use which format (URT, 2008a:4). As a result,

these planning and reporting guidelines have not achieved their intended purposes of ensuring citizen voices in the planning and reporting as well as accountability of health service providers to citizens.

In spite of all these processes at the district level, and legal requirement for Full Council Meetings to approve individual council annual plans, the final content of each individual CCHP is determined by the Ministry of Health and Social Welfare (MoHSW) jointly with Prime Minister's Office for Regional Administration and Local Government (PMORALG). The excerpt below provides evidence.

> *Most plans included the P4P[3] budget as instructed. Those Councils and Regions that under budgeted or missed the P4P budgets were called through telephone and instructed to correct their plans, to comply with these policy requirements (URT, 2008a:5)*

This implies that, central ministries are fully in control of priorities and processes for district authorities planning and reporting. Legal and policy prescriptions for roles of citizen and autonomy of Health Facility Governing bodies and that of the Council in planning, implementation and reporting are reduced to mere rhetoric by simply a telephone call from the central government.

2.4 Health Financing at District Level

Health Sector in Tanzania receives about 11 percent of total government spending. However, financial decentralization as a measure to ensure sufficient budget for district authorities and implementation of decentralization by devolution is yet to be adequately implemented in the health sector. For example, share of health sector budget which goes to the district authorities is usually less than 40 percent (MoHSW, 2008). This implies greater financial powers by the central ministry whose role is policy, regulation and quality control and less for local governments who are responsible for the delivery of health care services to citizens.

Finances for district health service delivery in Tanzania are from five different sources. Health Block Grant and Health Basket Funding from central government which are the major source of health financing at district level, followed by Cost Sharing, Council's Own Funds, and Other Sources (URT, 2008a). Health service providers are expected to make good use of all these funds while citizens are expected to play their civic role of holding service providers to account in case of any misuse or abuse.

2.5 Financial Management and Social Accountability

Analysis of audit reports for the Temeke Municipal Council for the years 2004 - 2007 points to general cases of possible poor management, misuse or abuse of public funds as evidenced by a number of recurring and unresolved audit queries each financial year (URT, 2005b, 2006a, 2007e, and 2008b). Major shortcomings of these reports are in

their inability to provide detailed account of management and use of funds for the council's health department, and that they are written in highly technical language and format for ordinary citizens to understand. Notwithstanding this, they are also not publicized by respective Councils as required by law, hence citizen's inability to hold service providers to account.

In addition to audit reports, Council's Health Department annual technical financial performance reports are primarily submitted to PMORALG and MoHSW for funding requirements. These reports are also insufficient source of judgment on the status of the department's financial management and performance (URT, 2007f, and 2008c). It is unclear whether activity and financial performance reports of the whole Health Department are shared with management of individual health facilities or communities they serve.

Integrity in the use of public funds is also the concern of the President of the United Republic of Tanzania, as affirmed below;

> *Lakini Kama kwenye upande WA matumizi hakutakuwa Na nidhamu, kazi tunayoifanya ni kama vile tu unakwenda kuteka maji unayamwaga kwenye pipa lililotoboka. Hiyo ni biashara kichaa, hatuko tayari kuifanya biashara hiyo (Kikwete, 2008:16).*

(Translation: If we have no discipline on the side of expenditures, it will be as if we are filling water in a holed tank. This is a crazy business; we are not ready to do it).

2.6 Access to Information

Citizens' access and right to information is a universal human right enshrined in the Universal Human Rights Declarations. This right is stipulated in article 18 of the Constitution of the United Republic of Tanzania (URT, 2005a). Access to information is one of the means to facilitate interaction between service users and service providers. Citizen friendly information regarding annual plans and planning processes, budget, implementation and financial audited reports is necessary for citizen participation in local government service delivery. Consequently, free accessibility to this information will increase legitimacy of local government and enable citizens to hold their political leaders and technocrats accountable for any abuse or misuse of public resources (Fjeldstad, 2004), as well as shape quality and choice of services delivered.

Local government authorities are required by law to publicize information on public finances to its citizens, including the signed audited reports (URT, 2000b: article 49). However, the government of Tanzania acknowledges that there are weaknesses in the flow of information both downward and upward within councils (URT, 2007c). The proportion of village/mtaa notice boards posting information about government income and expenditure in Tanzania is only 19 percent (URT, 2007d). It is unclear whether or not budget and expenditures of health department are part of the posted information. Fjeldstad (2004) gives more evidence that only 7 percent of citizens saw information on local government budget, 3 percent on audited statements of council expenditures and 4 percent on sectors financial allocation.

In terms of demand for information, regrettably, most citizens do not ask for information from district, ward, and mtaa[4] levels. In Dar es Salaam region, only 7 percent of people request information from district level, 14 and 10 percent from ward and mtaa respectively (URT. 2007a pp 52-53:). In addition, public officials are reluctant to share written information with the public on assumption that people would not read (Mushi et al, 2005).

2.7 Accountability of Public Officials

Poverty and Human Development Report (2007) points to evidence of general lack of accountability of public officials, although there is no specific literature documenting the situation in the district department of health. However, government health service providers, members of health facility governing committees and local leaders are expected to be accountable to citizens. In Dar es Salaam region, only 30% of people are aware of officials who were accused in public of misusing resources intended for a development activity. Another 32% is aware of officials who were dismissed for poor performance or corruption. Only 19% of citizens in Tanzania perceive that the current government is very effective in the fight against corruption (URT, 2007d)

2.8 Quality of Health Care

According to the Tanzania Demographic Health Survey, while there is some improvement in some of the indicators for health, there is deterioration in others. The total fertility rate is up from 5.6 children per woman in 1999 to 5.7 in 2004. Under-five mortality has improved from 146.6 per 1,000 live births in 1999 to 112 in 2004 while maternal mortality is up from 529 per 100,000 live births in 1996 to 578 in 2004. Although 94% of mothers received antenatal care from a trained service provider for their most recent birth, only 46% of the deliveries are attended by a health professional (URT, 2004/5).

In its efforts to ensure quality healthcare services and rights of service users, MoHSW developed the Client Service Charter for use with both healthcare service providers and users. It outlines services to be offered to citizens, roles and responsibilities of service providers and users, rights, guiding principles, and complaint mechanisms (URT, 2002).

It has been reported that 38% of people in Tanzania are satisfied with the health care services at dispensary level (Braathen et al, 2005). In Dar es Salaam region alone, citizens cite problems encountered with healthcare services such as cost of treatment and drugs (62%), availability of drugs (50%), time waiting to be served (55%), accessing health facility (34%), politeness of health staff (25%), availability of maternity services (13%), and cleanliness of facilities (10%) [URT, 2007a pp 35 -36]

2.9 Corruption in public health care

Unofficial payment in the form of bribery is responsible for loss of lives, disability, poor quality health status and care. The type of corruption referred to here is that which takes place at the point of health care delivery. This form of corruption usually occurs by way of extorting or accepting under the table payments for services that are supposed to be provided for free of charge; or soliciting payments in exchange for special privileges or treatment (Transparency International, 2006).

According to unpublished study by Muhondwa, et al (2008), 82% of citizens in Dar es Salaam and Coast regions admit that corruption exists in the public health facilities. Interestingly, circumstances reported by these citizens as reasons for transaction of bribe relatively link to the elements outlined above for measuring quality of health care. The circumstances include:

- Staff taking advantage of shortage of resources to press for bribery (58%)
- Improper service provision, e.g. Insensitivity of midwives to pregnant women (61%)
- Doctors absenting themselves causing congestion outside consultation rooms 70%)
- Staff telling patient lies that a certain service is unavailable (69%)
- Staff behaviors of extending favors to some patients (77%).

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- Staff taking advantage of patient ignorance of the services delivery processes (47%)

2.10 Community Participation

Participation is de-professionalization in all domains of life – schooling, health care, transportation, planning – so as to make ordinary people responsible for their own well-being. Participation should be superior to elite decision making, that is, treating people as subjects rather than objects of their own development (Goulet, 1995). The roots of citizen participation can be traced to ancient Greece in the writings of Plato and Aristotle (Copleston, 1993). Citizen participation[5] is one of qualities of democratic good governance which provides individual citizens with information, space and capabilities to influence policy and service delivery at all levels of government.

Community participation is a factor found to have association with levels of accountability of public health services since it gives citizens power and ability to make choices over health inputs and their capacity to use those choices toward health (Loewenson, 2004). Before 1990s in Tanzania, governmental processes and procedures were designed to facilitate public participation through the ruling single political party. Nyerere (1973) asserts that:

[5] In this thesis the terms "citizen" , "community" or "public," and "involvement" and "participation" are used interchangeably.

> *"Sovereignty of the people is the most important because the good of the people is the only legitimate purpose of all national activities, and only the people themselves can say what is to their good (p.35). People must be allowed to make their own decisions, and therefore their own mistakes. We can advice and warn, but if we try to run them we are destroying them (p.8)."*

Interestingly, 52 percent of respondents in Dar es Salaam expressed that participation in public affairs make a difference while 39 percent believe that participation will make no difference. In addition, 67 percent of respondents in Dar es Salaam have the opinion that people should be more involved in decision making about public affairs (URT. 2007a pp 52-53:).

3.0 METHODOLOGY

3.1 Demographic description of the study area

This research was done in Temeke Municipal Council, which is one of the three Municipalities of Dar es Salaam City Council, with an estimated area of 656 square kilometers. The population Temeke Municipal Council is estimated to be of 927,310 people with annual growth rate of 4.6%. Other municipalities are Kinondoni and Ilala. Temeke Municipality is divided into 3 divisions and 24 Wards. Health services provided in the Municipality include preventive, promotive, rehabilitative, and curative.

According to the Council Comprehensive Health Plan of Temeke Municiplal Council 2008/09, Temeke has four hospitals (two public and 2 private owned), four health centers (1 public, 3 privately owned) and 101 dispensaries (26 public, 75 private owned). In addition, the Temeke Municipal has 24 pharmacies and 350 part II drug shops. Generally, the population in Temeke access health services within the average of 5 kilometers from the residence.

The less than five mortality rate is 154/1000 and Maternal Mortality Rate is 524 per 100,000 live births. The top five causes of out patient morbidity, in order, are Malaria, Acute Respiratory Infections, Diarrhea diseases, Intestinal Worms, and Pneumonia. The top five causes of deaths in under five children in Temeke Municipal Council are Severe

Malaria, Pneumonia, Anemia, Diarrhea diseases. The top five major causes of deaths among adults are severe malaria, Clinical AIDS, Pneumonia, Tuberculosis, and Anemia.

3.2 Study Design

A cross-sectional design was used, using a combination of both qualitative and quantitative approaches of data collection methods.

3.3 Data Collection

3.3.1 Sources and Methods

Data was collected using semi-structured questionnaires. Observation of public notice boards in 24 out of total of 29 health care facilities was done in Temeke Municipal council. Three in-depth interviews were conducted to three key informants identified from the semi-structure questionnaire administered. These were considered to have in-depth knowledge regarding issues of accountability. Finally, analysis of key policy and legislative documents was done.

3.3.2 Description of Methods

Semi-structured questionnaire: A mixture of closed and open-ended questions were asked (see appendix A) to 432 individuals at household level (one person per a household who is of legal age, male or female accessing public or private health facilities, or a combination of the two). The questionnaires were structured to elicit

choices between alternative answers to pre-formulated questions; and also open ended questions giving respondents opportunity to express in their own way any views and experience they may have on the question asked.

In-depth interviews: Three in-depth interviews were conducted with two females and one male informant who have knowledge and experiences regarding accountability issues in public health care. They were identified during the administration of household semi-structured questionnaires.

Observations of information on public notice boards: Notice boards in all 24 out of 29 public health facilities in Temeke Municipal Council were observed, using a pre-designed checklist (please see appendix C). The aim was to assess whether they post information and type of information posted.

Policy analysis: The researcher critically analyzed a number of policies he was able to access which relate to governance and accountability in relation to health care service delivery. Documents analyzed are the Constitution of the United Republic of Tanzania, Local Government Laws, National Health Policy, and Health Sector Strategic Plan III. Others were the Local Government Reform Programme and Guidelines for the formulation of district health plans.

3.4 Sample size calculations

3.4A. Sample size for household survey was calculated based on the formula;

$$n = \frac{z^2 p (1-p)}{d^2}$$

whereby:

n= the minimum sample size estimated

z = z value (corresponding to the 95% confidence level) equals to 1.96

p= expected proportion of people who perceive that the public health care in Temeke District is accountable to health service users. Since there is no study already done to determine this proportion, an assumption of 50% was made.

d = absolute precision. That is, the margin of error around the prevalence (p), set at 5%.

$$n = \frac{1.96^2 \times 0.5 (0.5)}{0.05^2} \qquad n=384$$

I chose to add an estimated 10% for non-response to 384, hence the minimum sample size was at least 422 people.

3.4B. Sample size for observation of notice boards

Public Notice boards in all 29 public health facilities in Temeke Municipal Council were intended to be observed. However, the researcher managed to observe notice boards on 24 health facilities only due to time and resources limitation. This is about 83% of all public health facilities in Temeke Municipal Council.

3.5. Model specification

The concepts of transparency and answerability were used as measures of accountability along with the analysis of policy documents. Transparency exists when much is known by service users about plans, finances and performance of annual plans for health facilities. Answerability, on the other hand, is the degree to which health care services are satisfactory to service users. Deliberately, the researcher did not ask the respondents to air out their views as to whether the public health facilities were answerable (or transparent) or not, instead the researcher made a number of variables (questions) that reflect the presence or absence of both transparency and answerability.

The target of the estimation was, first, to determine whether or not there is association between dependent and explanatory variables about accountability. Second, to determine the direction and magnitude of influence each of the variables have on the dependent variables. The estimation done was thus interested in answering mainly two questions: First what is the nature of relationship between the variables (dependent and explanatory variables)? Second what is the magnitude of impact each of the explanatory variables have on the dependent variable (answerability/transparency).

As it will be explained below, dependent variables were constructed by combining a set of indicators into one variable. Pearson chi-square was used to determine whether or not there is any significant relationship between each independent variable and its

corresponding dependent variable. Significance level used was 10%. Logit regression was then run to find estimations for transparency and answerability models respectively.

Prior to the estimation of the models, I undertook various tests to ensure that the ultimate results are efficient, unbiased and consistent. The study looked into the diagnostics of logit regression to see whether the model omitted important variables or included an extraneous variable. Also I looked into whether my model fitted the data well or not by performing goodness of fit test. The test of multicollinearity was also performed to check whether there is any significant linear association among the independent variables in the model and finally the study assessed whether there is heteroscedasticity problem in my model. As a result of the prior estimation tests, it was found that the data set did not seriously suffer from the violation of any of these assumptions.

The dependent variables are categorical (binary) with values, 1 if there exists answerability (or transparency) and zero if there is no answerability (or transparency). A respondent is considered to perceive the public health care system is answerable (or transparent) if at least one of the indicators are reported in favor of the answerability (or transparency) by the respondent. Otherwise, the respondent is considered to perceive the system not being answerable (or transparent). The dependent variable takes a value of 1 if the respondent is considered answerable (or transparent) and zero if not.

3.5.1. Dummy variables for dependent variable transparency

In addition to chi-square tests, accountability was estimated using two different logit models which are transparency and answerability. As for Transparency, the table below presents a set of the generated dummy variables and their a prior expectations:

Table 1: Dummy variables for Dependent variable Transparency

S/N	Generated dummy variable	Explanations
1	*Near*	This explains the distance from the health facility. It takes a value of 1 if one lives near the facility and 0 if lives far
2	*Secondary*	This explains the level of education of the respondent. It takes a value of 1 if a respondent has at least a secondary education and 0 if the respondent has less than the secondary education
3	*Public*	Explains the type of health facility often visited by the respondent. It takes a value of 1 if respondent visits either public or private facilities or both and 0 if respondent only visits private facility
4	*Participate*	This explains whether the community participates in the planning, and budgeting. It takes a value of 1 if he/she participates and zero if he/she does not.
5	*Sawcharter*	This explains whether a respondent ever saw the health service clients' charter from the ministry or not. It takes a value of 1 if ever saw and 0 otherwise.
6	*Demanded*	This explains whether the respondent ever demanded any accountability related information from the health facility. It takes a value of 1 if demanded and 0 otherwise.

The estimated model is therefore given below:

$$Trans = \beta_0 + \beta_1 Age + \beta_2 near + \beta_3 \text{sec} + \beta_4 pub + \beta_5 part + \beta_6 sawchart + \beta_7 dem + \varepsilon$$

Where *sec* stands for *secondary*, *pub* for *public*, *part* for *participation sawchart* for *sawcharter*, dem for *demanded* and ε for an *error term*. Trans is the dependent variable explaining whether the respondent perceives the health facility transparent or not. Where β are the coefficient parameters of the independent variables and ε is an error term.

3.5.1. Dummy variables for dependent variable answerability

Due to the fact that majority of the independent variables are categorical, generation of relevant dummy variables was also important for the estimation and interpretation purposes. The table below summarizes a set of independent variables used in the estimation process.

Table 2: Dummy variables for Dependent variable Answerability

S/N	Generated dummy variable	Explanations
1	Aware_board	This captures whether the respondent is aware of the existence of health board and facility committees. It takes value of 1 if YES and 0 if NO
2	Aware_meeting	This captures whether the respondent is aware of any meeting of the governing committees of the health facility. It takes value of 1 if YES and 0 if NO
3	Complaints	This captures whether a respondent knows how to lodge complaints against unsatisfactory health care services. It takes value of 1 if YES and 0 if NO
4	Secondary	This explains the level of education of the respondent. It takes a value of 1 if a respondent has at least a secondary education and 0 if the respondent has less than the secondary education
5	s_waiting	Whether respondent is satisfied with the time waiting to be served. It takes value of 1 if YES and 0 if NO
6	s_labservices	Whether respondent is satisfied with the availability of laboratory services. It takes value of 1 if YES and 0 if NO
7	s_costlab	Whether respondent is satisfied with the cost of laboratory services. It takes value of 1 if YES and 0 if NO
8	s_medicine	Whether respondent is satisfied with the availability of the medicine. It takes value of 1 if YES and 0 if NO
9	s_costmedic	Whether respondent is satisfied with the cost of medicine. It takes value of 1 if YES and 0 if NO
10	s_cleanliness	Whether respondent is satisfied with the cleanliness of the environment. It takes value of 1 if YES and 0 if NO
11	s_reception	Whether respondent is satisfied with the reception services. It takes value of 1 if YES and 0 if NO
12	s_explanation	Whether respondent is satisfied with the explanation given to him/her. It takes value of 1 if YES and 0 if NO
13	s_treatment	Whether respondent is satisfied with the kind of treatment given. It takes value of 1 if YES and 0 if NO
14	s_confidentiality	Whether respondent is satisfied with the degree of confidentiality during consultation.

The estimated model is therefore given below:

$$Answer = \alpha_0 + \alpha_1 \text{sec} + \alpha_2 aware\_board + \alpha_3 aware\_meetimg + \alpha_4 compla\text{int}s\ \alpha_5 s\_waiting$$
$$+ \alpha_6 s\_labservices + \alpha_7 s\_\cos tlab + \alpha_8 s\_medicine + \alpha_9 s\_\cos tmedic + \alpha_{10} s\_cleanliness$$
$$+ \alpha_{11} s\_reception + \alpha_{13} s\_\exp lanation + \alpha_{14} s\_treatment$$
$$+ \alpha_{15} s\_confidentiality + \varepsilon$$

Where $\alpha_i's$ are the coefficient parameters of the independent variables and ε is an error term.

3.5.3. Justification of Variables used

3.5.3.1. The Dependent Variable Transparency

In determining the existence of transparency as the dependent variable, the researcher defined the existence of transparency when at least one of these variables showed *an answer* **YES,** thus the variables that have defined the existence of transparency or not are:

(i) *Whether budget for the delivery of health care services, periodic implementation reports, and budget expenditure reports for a particular health facility were posted on a public place for citizens to see:* It is the researcher's view that, there is an indication of transparency in any given health facility if it has a tendency of

posting the requisite information on the board for everyone to read. Question 15a inquired about whether respondents had seen health care plans posted on public notice boards at health facilities. This kind of information is in contrast with the traditional information regarding health promotion and education which is generally abundant in our health facilities, and for which question 15a was misunderstood to imply that. Posting of the requisite information is likely to stimulate inquisitiveness of citizens regarding processes for planning, implementation and reporting of health care delivery. It is thus taken as way of facilitating transparency.

(ii) *Whether the respondent ever seen the audit report:* It is from the audit report; the opinions of the auditor would be aired to the citizens. If this report is made available to citizens, then there must be transparency in one way or the other. Thus the researcher finds it more appealing to define Transparency if there is openness on this.

(iii) *Whether respondents are given information or not upon demand:* It is the researcher's view that, transparency will only exist if any citizen at anytime may be given information upon demand. This accelerates more on transparency and thus Accountability.

(iv) *Sharing of facility plans, budgets and implementation reports:* This factor was used to define the existence of transparency basing on the fact that sharing the particular information welcomes critics, suggestions as a result creates a way of mirroring various actions.

3.5.3.2. Justification for the dependent variable transparency

It is an opinion of the researcher that, there are various variables that lead to existence of transparency of public health care facilities and these are:

(i) *Education:* Education creates awareness (like what information should one see and should one demand!), curiosity (like questioning for various information such as seeing the audit report) and ability to demand one's right (like demanding information that one is obligated to be given). The study thus pre-supposed that, a citizen who is educated is more likely to either enhance transparency or be able to demand for it or see it than a citizen who is not. Therefore, the higher one is educated, the more one is likely in seeing features of transparency since low level of education creates lack of confidence, more of un-necessary complaints, dissatisfaction etc.

(ii) *The type of health facility (whether public and private or private only):* The researcher realizes the fact that, public health facilities are more responsible to openness than it is for private ones. Citizens have a greater sense of

ownership in public health facilities than it is to private health facilities. One of the reasons for this phenomenon is the taxes citizens pay that is expected to be reflected in public services like this. Therefore, the study expected the type of health facility is likely to determine the existence of transparency or not.

(iii) *Age of the respondent*: The study pre-supposes that, one's age may determine/relates more with one's level of education, experience, maturity and awareness. The combination of these features, affect one's ability to realize and appreciate the existence of transparency or not in any institution. For example, maturity and experience determine one's ability in demanding any information, awareness enables a citizen to know for sure the type of information a health facility should provide upon demand etc. It is in this sense the study uses age as an explanatory variable for the existence of transparency or not.

(iv) *Citizen's distance to the health facility he/she frequently attends:* The study pre-supposes that, the existence of transparency or not may highly be affected with how far or near one is to the health facility. The study expects that, an individual who attends and stays near to the health facility is more likely to have a better picture on the existence of transparency through its features than a citizen who attends and stays to the health facility that is far from area of residence.

(v) *Whether a Citizen has ever demanded information or not:* The study establishes that, a citizen who has ever or who demands various information is the one who is first of all aware and secondly is the one who is likely to sense the status of the existence of transparency or not. The study recognizes the fact that not every information can easily be disclosed unless upon demand.

(vi) *Participation in the annual planning and budgeting:* Participation creates awareness, ability and confidence to make proper follow up, proper judgment and sometimes participation calls for transparency. It is from this fact, the study presumes that the more one is made to participate the more one is likely to appreciate the existence of transparency through its features or not. A citizen who is regularly made to participate is more likely to say as to whether there is openness or not. Moreover, participation leads to transparency since through participation citizens call for transparency. The important note is that, it is very difficult for a citizen to know on the openness of a given health facility if he/she does not participate anyhow.

(vii) *Ever seen the client charter of the ministry*: It is the researcher's view that, there is an indication of transparency in any given health facility if it has made possible its client to see the client charter of the ministry. The study

expects the client charter to educate the client more on his/her right from the health facility thus helping to prevent unwanted cases.

Each variable at a time is assumed to influence the status of satisfaction in a different way and thus answerability. The study presupposes that, the happier one is in each of these, the more one is likely to have little or no complaints, the more there is little or no possibility of bribery and the more one is likely to be happy with the attitude of service providers thus be positive with answerability as the dependent variable.

3.6 Sampling procedure

The sampling frame for this research was 46 out of 70 administrative streets in Temeke Municipal Council. This means two administrative streets were picked from each of 24 wards of Temeke Municipal Council. Criteria for the two streets were one administrative street in which there is a health facility and another which is the furthest from the health facility. To determine which street is close or far from the health facility, Ward Executive Officers were asked at the time when a researcher or his assistant reported to the Ward office.

Nine respondents were interviewed in each administrative street representing five males and four females or five females and four males as the case may be in order to obtain a

total of 9 females and 9 males in each Ward. This means that a total of 432 (216 males and 216) females) respondents were interviewed using semi-structured questionnaires.

To identify households from which to pick respondents, researcher/research assistant started from either a health facility where one exists or any public office where none exists in that particular street. While standing at that particular point facing either the office or health facility, a coin was tossed to determine the direction from which to start sampling. Head meant left direction and tail meant right direction. Once the direction was determined a third household from that point was the first to enter.

While in the household, any person of legal age who is met first was asked to participate in the research. If for some reasons was unable to participate, another one was asked. The procedure was if the first interviewee turned out to be male the next one was supposed to be a female and so on until the number of respondents in that particular street was exhausted. The rest of households were obtained by skipping two households and entering the third until all nine households were obtained.

3.7 Data processing, analysis and presentation

Quantitative data: All semi-structured questionnaires and checklists were numbered before data collection to facilitate reference. Template for entering data was created with the help of statistician and data were entered into computer using Statistical Package for

Social Sciences (SPSS) and later on transformed into STATA. Proportions were generated for each closed question after some cleaning of data. Measures of central tendency and dispersion on demographic characteristics of respondents were generated using SPSS. Chi-square and Logistical regression analysis was done by using STATA software to predict association, strength, direction and effect of selected independent variables on dependent ones.

Qualitative data: Responses for open-ended question in the semi-structured household questionnaires were categorized, coded and entered in to SPSS. Analysis was done using SPSS to determine frequencies for responses. Results have been presented in explanation to proportions from closed-ended questions.

The three in-depth interviews were recorded in audio tapes (with permission from the interviewees) and later transcribed. Table of summaries of key points relating to experiences and perceptions of accountability of public health facilities in Temeke Municipal Council was generated. Some quotations in relation to the results from quantitative data were identified, translated into English and used to support the discussion part of this report.

Notice board observation: Analysis of data collected from the observation of information on public notice boards of public health facilities was done using SPSS. Proportion of public health care facilities with public notice boards was calculated.

Percentages of types of information posted on public notice boards were also calculated and presented in the results section.

Policy and legislative analysis: A desk review of all accessed documents was done and all documents used are referenced. Conclusions are made based on researcher's own judgment.

3.8 Human resource

The researcher was responsible for planning, overseeing, and implementing the research activities. He recruited a main assistant to help with the supervision and trouble shooting in case research assistants faced any difficulties during actual data collection. Twelve research assistants were recruited for data collection while a statistician was hired to guide the researcher for entering raw data into SPSS and analysis. A help of an economist was sought to help with the econometric model in collaboration with the researcher and the statistician. Each research assistant administered 36 questionnaires in two different Wards. All research assistants were trained on basic skills of administering questionnaire and rapport building.

3.9 Ethical issues

Ethical clearance was obtained from MUHAS Research and Publications Committee. Research permit was obtained from the District Administrative Secretary in Temeke Municipal Council through the Dar es Salaam Regional Administrative Secretary. Upon

are out for their livelihood activities during the time, the type of respondents may have been biased toward those who are self employed or unemployed. This limitation, again, does not constitute a major threat to the validity of data since all individuals regardless of their socio-economic status have experiences with health care services.

CHAPTER FOUR: FINDINGS

4.1. Characteristics of the sample population

A total of 432 respondents were interviewed; their socio-demographic characteristics are shown in Tables 3 and 4. The sex ratio of the study population was 1:1 with an age range of 16 to 81 years and a mean age of 35 years.

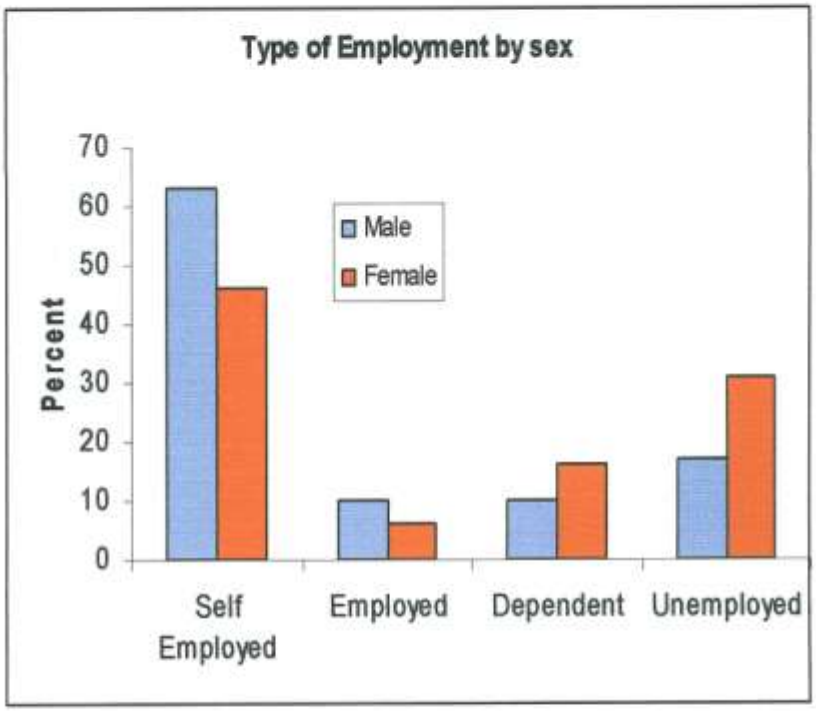
Table 3: Socio-demographic characteristics of the study population n=432

Socio-demographic characteristics		Number	Percentage
Has children under five years	Has children under five	194	45
	Has no children under five	238	55
If female, Pregnant?	Pregnant	23	11
	Not pregnant	193	89
Live near of far from health facility?	Near	216	50
	Far	216	50

Table 4 Socio-demographic characteristics of the study population n=432

Socio-demographic characteristics		Number	Percentage
Age	≤31	219	50.8
	>31 ≤ 44	131	30
	>44 ≤ 81	82	19
	Does not know	1	0.2
Sex	Female	216	50
	Male	216	50
Religion	Muslim	297	69
	Christian	135	31
Level of Education	Illiterate	36	8
	Primary school	284	66
	Secondary school	75	17
	Vocational training	14	3
	Degree/diploma	5	1
	Others	18	4
Occupation	Self-employed	239	55
	Employed	34	8
	Dependent	56	13
	Unemployed	103	24
If respondents own or rent a house	Own house they live in	246	57
	Rent house they live in	186	43

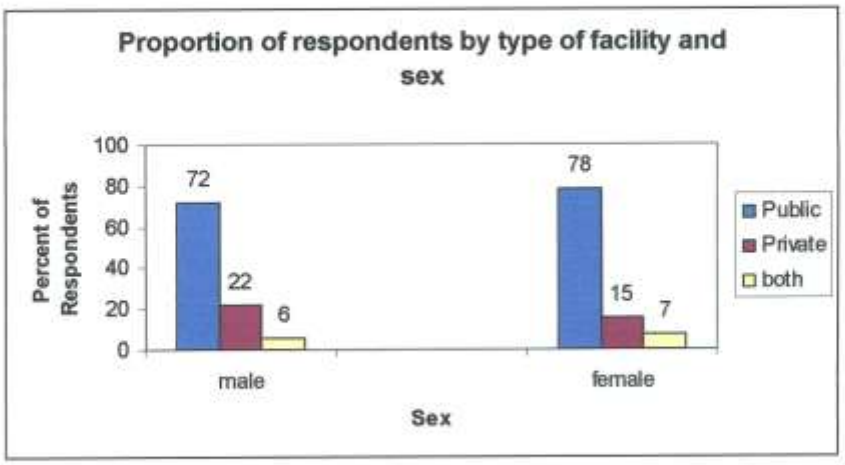
Graph 1: Distribution of employment and house ownership by sex



4.2. Types of facilities visited by respondents

Respondents were asked about the type of health care facilities they (or their families) visit when they get sick. Seventy-five percent of respondents (324) do access health care services in public health facilities. Seven percent of respondents (28) visit both facilities while 19 percent (80) access health care only in private facilities The graph below presents distribution of type of facilities visited by respondents by sex

Graph 2: Proportion of respondents by type of health facility by sex



As seen in the Graph 2, the majority of respondents attend public health facilities whenever they are sick. Table 5 below presents multiple responses for reasons why most respondents attend public health care facilities.

Table 5: Reasons for attending public health care facilities (Multiple responses)

Reason	Count	Percentage
I don't know	1	0.2
They provide quality health services	79	19.7
We do not have private facilities around	15	3.7
Public hospitals are cheap	157	39.2
We have low economic status	33	8.2
Public hospitals are closer to our residences	66	16.5
They have qualified health workers	50	12.5
Total responses	401	100.0

4.3. Quantitative results about transparency

This part of data intended to provide information to the first objective of this study which regards the flow of information from health facilities and health committees to citizens. The information referred in this study is that related to health care service planning, budgeting and reporting. The table below summarizes all types of information respondents were asked whether they have seen or demanded. At the end of the table an average percent score is calculated to generally help the researcher to conclude if the public health care system in Temeke Municipal is transparent or not.

Table 6: Results for Determinants of flow of Transparency, percent

Sn	Variable	Percent		N	Yes x N/100	No x N/100
		Yes	No			
1	Do you usually find information posted on public notice board	82	18	378*	309.96	68.04
2	Health plans on the notice boards	72	28	432	311.04	120.96
3	Health budgets on the notice boards	13	87	309	40.17	268.83
4	Implementation reports of health services on notice boards	16	84	309	49.44	259.56
5	Health services budget expenditure reports on notice boards	14	86	309	43.26	265.74
6	Able to understand information posted on notice boards	39	61	309	120.51	188.49
7	Ever seen Council's audit report	2	98	392	7.84	384.16
8	Ever demanded information	1	99	421	4.21	416.79
	Total			**2859**	**886.43**	**1972.57**
	Average percent score				31%	69%

*Don't know 12% (54) not included, percentage for reminder recalculated. The varying numbers of respondents was due to the fact that respondents were filtered by a preceding question, the results of which are not included in this table.

4.4. Information posting on public place at health facility

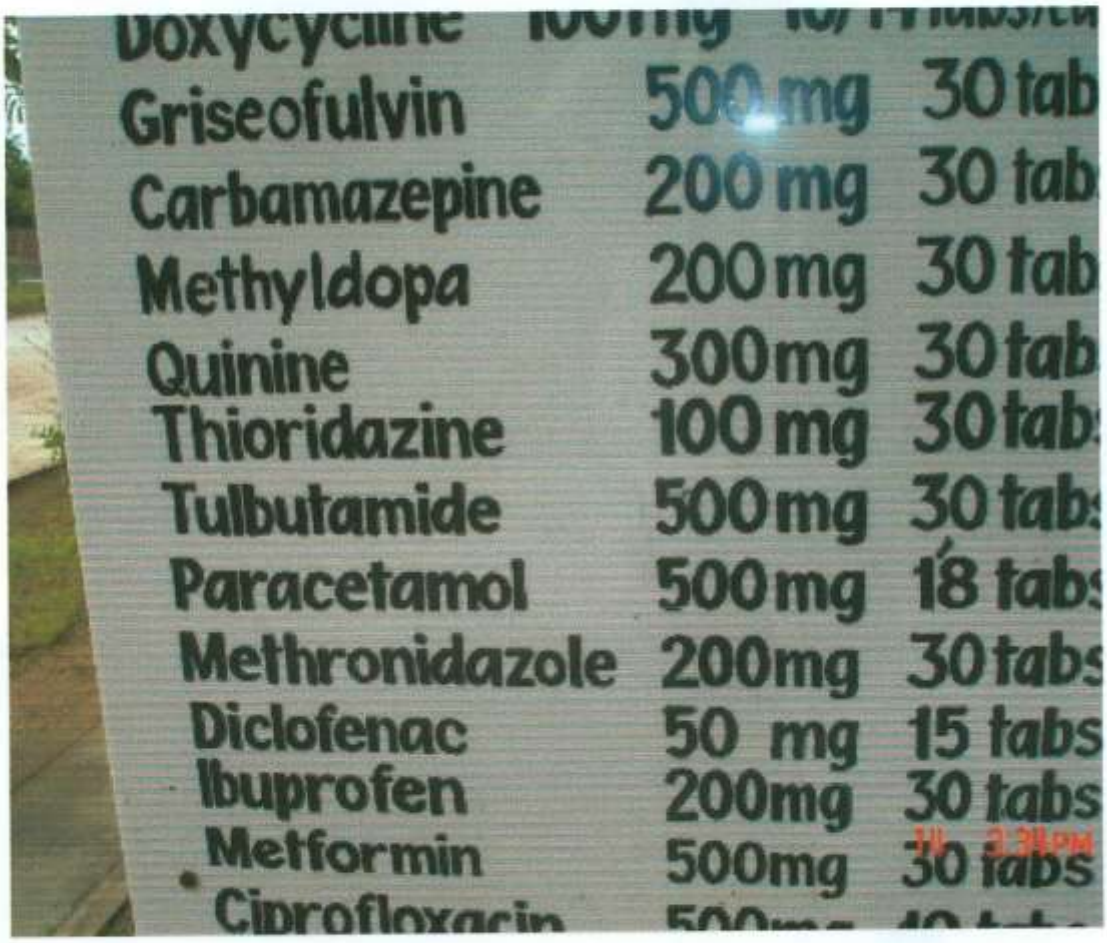
Generally, respondents affirm that information was posted on public place. The question is what kind of information was posted on public place for citizens to access? The kind of information of interest to this study was not posted, rather general information regarding health promotion and education and pricing for different services.

In addition to responses from the sample population regarding whether or not the requisite information is posted on public place for citizens to access, the researcher observed 24 health facilities using a pre-designed checklist to find out if the requisite information was actually posted. The composition of the 24 health facilities observed was 20 dispensaries, one health center, two hospitals and one MCH clinic. The following table presents results for observation of whether or not information was posted on public place at government health facility.

Table 7: Number of public facilities posting information publicly

Type of information	Posted	Not posted
a. Annual work plan of the facility	0	24
b. Annual budget of the facility	0	24
c. Funds disbursement received	0	24
d. Quarterly work plan of the facility	0	24
e. Quarterly budget of the facility	0	24
f. Summary of activities implemented	0	24
g. Budget expenditure reports	0	24
h. Schedule of Facility Committee meetings	2	22
i. Minutes of Facility Committee meetings	0	24
j. Announcements regarding types of health care services available	13	11
k. Announcement regarding any unavailable health care services	2	22
l. Types of service providers available	3	21
m. Prices charged for various services	10	14
n. Suggestion Box	14	10
o. What other information do you see (please list)	22	2

The following pictures were taken to show type of information posted on public place at health facility.



Portion of Notice board for prices of various medicines

Example of health promotion and education information

A notice board with announcements posted at one of the health facilities

4.5. Level of education and ability to understand information

As evident in the table below, level of education does not matter for citizens to understand information posted on public place at public health facilities.

Table 8: Level of education and ability to understand information, percent

Education level	Could understand	Could not understand	N
None	21	79	24
Primary school	42	58	200
Secondary school	32	68	60
Vocational	75	25	12
Degree/diploma	0	100	3

Source: Author's calculations of multiple responses analysis

4.6. Information demanded by citizens

Ninety-nine percent of respondents did not demand information on health plans, budgets, and implementation progress. In an open ended question, they were asked to list reasons as to why they usually do not demand this information. Table 9 below presents list of reasons mentioned by respondents.

Table 9: Reasons for citizens not demanding information (Multiple responses)

Reasons	Count	Percentage
I don't know	56	12.9
Health workers don't value and respect citizen	82	18.8
Lack of awareness about service user's rights	210	48.4
Lack of confidence of health workers	35	8.1
No action taken to those who deny citizen information	51	11.8
Total responses	434	100.0

Respondents were also asked to list reasons, in their perspective, as to why health workers would not share this type of information even if requested. Table 10 below presents list of responses for this question.

Table 10: Reasons for service providers not sharing information (Multiple responses)

Reasons	Count	Percent
I don't know	54	22.8
Health workers don't value and respect citizens	36	15.2
To cover-up their corrupt deeds	100	42.2
Citizens are not assertive enough	36	15.2
They are not trained to be accountable to citizens	11	4.6
Total responses	237	100.0

4.7. Transparency estimation results

A set of independent variables is considered to have influence on the individual perception on the existence of transparency included the age of the respondent, the distance from the health facility, level of education of the respondent, type of the health facility used by the respondent, whether the respondent ever demanded any information from the public health facility, whether the community members participate in the planning and budgeting for the health facility; and whether the respondent had ever seen the client service charter of the Ministry of Health and Social Welfare[6].

Pearson chi-square tests were run using STATA computer software to determine if there was any association between each independent variable to the dependent variable involved in the transparency model. As for transparency, all six independent variables were found to have positive association to the dependent variable, four of which have significant association. These results are presented in table 12 below;

Table 11: Chi-square test Results for Determinants of Transparency

Sn	Independent variable	Variable attributes	N	Percent	Pearson chi2	p-value
1	Live near to the facility?	Yes	216	50%	0.6087	0.435
		No	216	50%		
2	Have at least Secondary level education?	Yes	96	22%	4.8591	0.028
		No	336	78%		
3	Access service in public health facility or both public and private	public and private	352	81%	1.9086	0.167
		private only	80	19%		
4	Have seen client service charter of Ministry of Health?	Yes	9	2%	5.1784	0.023
		No	388	98%		
5	Participated in health care planning and budgeting?	Yes	21	5%	15.9743	0.001
		No	402	95%		
6	Demanded information from health facilities?	Yes	6	1%	5.7624	0.016
		No	415	99%		

4.7.1 Estimation of results for transparency

Using the chi-square test, out of seven independent variables only two independent variables which were "whether respondent live near or far from the facility" and "whether respondent access services at public or private facility" were found to be insignificantly associated with the dependent variable. Therefore the two variables were omitted in the logistic regression model because the researcher wanted to include only significant independent variables into the multiple regression. Following the logistic estimation of the model, it was found that all independent variables were jointly and positively associated with the dependent variable.

The independent variables which are jointly and positively associated with the transparency are age of the respondent, whether or not the respondent had attained at least form four secondary education, whether or not the respondent had participated in the planning and budgeting of public health facility, whether or not the respondent had seen the client service charter, and whether or not the respondent had demanded information from the public health facility.

In addition, association and effect of two out of the five independent variables was significant at 95 percent confidence interval with varying magnitude, as presented in table 13 below. If respondents have at least form four secondary education is significantly associated with the ability to perceive the system to be transparent at $p = 0.051$. If the respondent participated in the planning and budgeting of the public health

facility was found to have significant association with the ability to perceive the system to be transparent at $p = 0.001$.

Interpreting the odds ratio, all independent variables had effect on the transparency. An additional unit in the age of respondent is 1.0 times more likely to find the public health care system transparent compared to individuals whose ages are less by one year. Respondents with at least form four secondary education were found to be 1.7 times more likely to find the public health care system compared to respondents with less education level. Respondents who had participated in the planning and budgeting of public health care facility were found to be 5.2 times more likely to find the public health care system transparent compared to respondents who had not participated. Respondents who had seen the client service charter of the Ministry of Health and Social Welfare are 4.5 times more likely to find the public health care system transparent compared to their counterparts who had not seen it. Finally, the odds ration indicate that respondents who had demanded information about health facility plans and budgets were 4.2 times more likely to find the public health care system transparent compared to those who had not demanded for such information. Tables for odds ratio are included at the back of this dissertation as appendix G.

Table 12: Logit Estimation Results for Determinants of Transparency

Variable	dy/dx	Std. Err.	z	P>|z|	[95% C.I.]	X
Age	0.002	0.002	1.12	0.264	-0.002 .006	34.517
Secondary*	0.109	0.056	1.95	0.051	-0.001 .218	0.263
Participate*	0.383	0.115	3.33	0.001	0.158 .608	0.050
Saw charter	0.353	0.315	1.12	0.262	-0.264 .969	0.008
Demanded	0.339	0.224	1.52	0.129	-0.099 .778	0.013

Source: Author's Calculations based on the field work

4.8. Quantitative results for answerability

This data is intended to provide information on the second objective of this study, regarding whether or not the public health care system in Temeke Municipal Council is answerable to citizens. Answerability is claimed to exist if at least 60% of Temeke residents (represented by the sample) are satisfied with the performance of the health workers, their participation in planning, absence of unofficial fees, and satisfaction with quality of public health care services. The chart below shows the share of citizens satisfied with the answerability indicators.

Table 13a: Results for Determinants of Answerability, percent

Sn	Variable	Percent		N	Yes x N/100	No x N/100
		Yes	No			
1	Know Member of Health Board or Committee	15	85	395	59.25	335.75
2	Heard of Council Health Board	17	83	402	68.34	333.66
3	Heard of Hospital Governing Committee	12	88	400	48	352
4	Heard of Health Center Committee	16	84	407	65.12	341.88
5	Heard of Ward Health Committee	21	79	401	84.21	316.79
6	Heard of Dispensary Committee	22	78	398	87.56	310.44
7	Aware of governing Committee meetings	16	84	430	68.8	361.2
8	Governing Committee members sharing information with citizens	9	91	419	37.71	381.29
9	Community participate in planning	5	95	423	21.15	401.85
10	No Complaints about health services	17	83	395	67.15	327.85
11	Knowledge of how to lodge complaints against unsatisfactory services	23	76	383	88.09	291.08
12	Seen Client Service Charter	2	98	397	7.94	389.06
13	No bribery in health care delivery	28	72	414	115.9	298.08
14	Satisfied with attitude of health workers?	34	66	432	146.8	285.12
15	Satisfied with time waiting to be served	39	61	429	167.3	261.69
16	Satisfied with availability of lab services	47	53	431	202.5	228.43
17	Satisfied with cost of laboratory services	54	46	429	231.6	197.34
18	Satisfied with availability of medicine	27	73	428	115.5	312.44
19	Satisfied with cost of medicine	32	66	427	136.6	281.82

Table 13b: Results for Determinants of Answerability, percent (continues)

Sn	Variable	Proportion		N	Yes x N/100	No x N/100
		Yes	No			
20	Satisfied with cleanliness of environment	63	37	430	270.9	159.1
21	Satisfied with reception services	53	46	431	228.43	198.26
22	Satisfied with explanation about your investigation/diagnosis	67	33	432	289.44	142.56
23	Satisfied with confidentiality during consultation	70	30	431	301.7	129.3
23	Satisfied with explanation you received about your illness	70	30	427	298.9	128.1
25	Satisfied with chance you were given to explain about your illness	71	29	430	305.3	124.7
26	Satisfied with treatment you received	42	58	431	181.02	249.98
27	Satisfied with clients seen on first come first served basis	50	50	431	215.5	215.5
28	Exempted groups getting free health care services	19	81	340	64.6	275.4
	Total			11623	3975.65	7630.7
	Average percent score			415	34%	66%

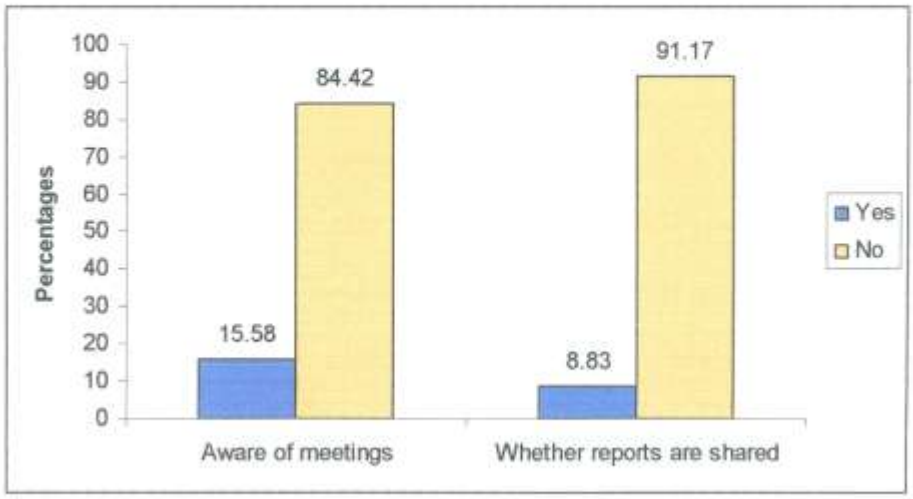
Therefore, if one assesses all the indicators of answerability, it is evident that the health service providers in the municipal are not answerable to the public. For the purpose of generalization, this study creates a variable that combines at least two of the indicators

and draws its conclusion from it. The study concludes that there is answerability if 60% of the respondents had positive responses to at least two of the indicators, otherwise no there is no answerability.

4.8.1 Interaction between Health facility governing committees and communities

As presented in Table 14 above, the majority of respondents are not aware of meetings or the existence of governing committees of health facilities. In open ended questions respondents were asked to mention roles of health facility governing committee. A significant number of respondents (197) said they do not know the roles of facility governing committees. Interestingly, another significant number of responses said that their roles are to provide information to citizens and to control income and expenditure of health facilities.

Graph 3: Respondents' awareness of committee meetings and information sharing



When respondents were asked to mention avenues under which members of health facility governing committee share facility plans, budgets and implementation reports, they mentioned only meetings and announcements. On the contrary, reasons for not sharing information by members of the governing committee varied. A majority of respondents (86 counts) declared that they do not know why this information is not shared with the community. Other respondents declared that committee members do not share information with the community because the community does not make follow up of such information. Absence of enforcement for members of the governing committee to share information with the communities they represent was also mentioned as one of the barriers.

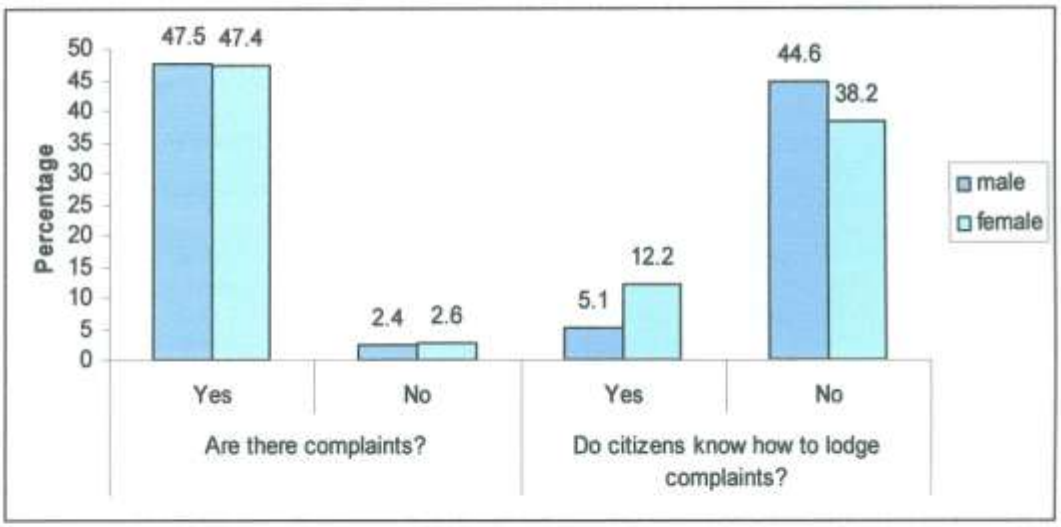
4.8.2. Community participation in health care planning

Reasons were solicited from respondents regarding participation and none participation of community members in the annual planning and budgeting of health facilities. Circumstance through which community members participate in this process is presented in Table 15 below. Reasons for not participating were diverse. The fact that citizens are not involved ranked number one followed by lack of civic awareness. The fact that it is not the intention of leaders to involve citizens in public planning was also mentioned

4.8.3. Complaints regarding delivery of health care services

The researcher was interested in finding out from respondents whether or not there are complaints against the delivery of public health care services. Results have already been presented in table 14 above but below is a graph comparing the same results by sex.. In addition, the graph also includes community's knowledge of lodging complaints by sex.

Graph 4: Complaints and knowledge of how to lodge complaints, by sex



When respondents were asked to mention a place where they usually lodge their complaints they mentioned suggestion box at the health facility, ward office, and public meetings. Again, when they were asked best ways they wished to present their complaints they mentioned suggestion box, public meeting to discuss complaints, ward office, and a suggestion to have a special office to deal with patient complaints. When

they were asked to mention types of complaints by citizens regarding public health services they gave a long list which was condensed and presented in Table 16 below.

Table 14: Types of complaints regarding public health care services (Multiple responses)

Category label	Count	Percentage
Poor quality of health services	303	36.9
Shortage of drugs	114	13.9
Bribery	105	12.8
Unfriendly attitude of health workers	86	10.5
Overcrowding	48	5.8
Unaffordable services	35	4.3
Shortage of health workers	20	2.4
Exempted groups are charged for service	19	2.3
Unclean environment	7	0.9
Queue not followed	5	0.6
Missing	80	9.7
Total responses	822	100.0

Respondents were then asked to tell their experiences regarding how complaints are responded to by health care providers. They said that complaints are usually dismissed by health care service providers on reasons that they are untrue. Quite often there are no responses and claims that those who complain are members of opposition political parties. When they were asked to suggest ways in which complaints should be responded to they mentioned a few. They suggest that the best ways to respond to complains is to address the problems which people are complaining about. Another suggestion is to use

public meetings, use of media to report how they have addressed the problems, and a follow up by members of governing committees.

4.8.4. Knowledge of service user's rights

Client Health Service Charter is a formal document which stipulates rights of both service providers and service users. It is already presented above that majority of citizens have not seen this document. Respondents were however asked if they know any rights of health services users. They mentioned the right to get free quality health care services. They also mentioned the right to be listened to, valued and received well by service providers. The last right mentioned is the right to confidentiality,

4.8.5. Corruption

Seventy-two percent of all respondents affirmed that bribery exists in the delivery of public health care services. Respondents were asked to list forms of bribery they encounter when accessing health care services

Table 15: Forms of bribes that exist in public health facilities (Multiple responses)

Category label	Count	%
Money	344	87.7
Nepotism	18	4.6
Sex	13	3.3
I don't know	17	4.4
Total responses	392	100.0

4.8.6. Health workers' attitudes

In addition to the closed-ended question regarding perception of respondents about attitudes of health workers, respondents were asked to mention types of health workers' attitudes they are unhappy about. The table below summaries major forms of health workers' attitudes which respondents are unhappy about.

Table 16: Kinds of health workers' attitudes service users are unhappy about*

Category label	Count	%
Unfriendliness to patients	73	40
Corruption	50	27.5
Poor health services	36	20
Unnecessary long waiting time	18	10
Lack of equipments for diagnosis	1	0.5
I don't know	4	2
Total responses	182	100.0

*Multiple responses analysis

4.8.7. Provision of free health care to exempted groups getting

One of the aspects of answerability the researcher was looking for was whether the health system implements free health care service for people with special needs as per the National Health Policy 2007. The graph and table below presents results from respondents regarding this aspect. The graph presents perceptions of respondents as to whether community groups who qualify for free health care service do actually get free

health care services. In another open ended question, the researcher wanted to know if respondents knew types of groups of people exempted from paying for services in public health care system. Table 19 presents list of answers from respondents regarding which groups of people are exempted from paying for health care services at public health care facilities.

Graph 5: If exempted groups do actually get free health care

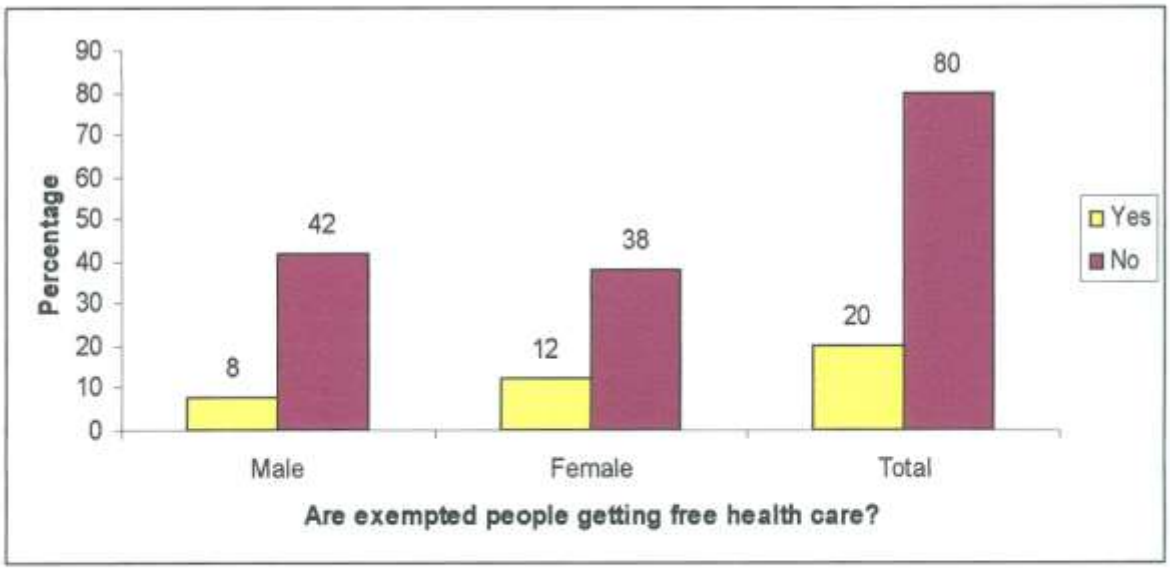


Table 17: People's awareness regarding exempted groups*

Category label	Count	Percentage
Children under five years	320	31.3
Elders	311	30.4
Pregnant women	187	18.3
Handicapped	130	13
People with chronic diseases	31	3
I don't know	31	3
No one get free services because we pay	12	1
Total responses	1022	100.0

* Multiple response analysis

4.8.8. Estimation of results for answerability

A set of variables that were considered to have influence on the answerability dependent variable included: whether a respondent is aware of existence of health board and facility committee, whether respondent is aware of any meetings of the governing committee of the health facility, whether respondent knows how to lodge complaints against unsatisfactory services from the public health facility, level of education of the respondent, whether respondent was happy with various services rendered by the public health facility when visited (including time waiting to be served, availability of laboratory services, cost of laboratory services, availability of medicine, cost of medicine, cleanliness of environment, reception services, explanation about the investigation/diagnosis made, confidentiality during consultation, explanation about the illness, chance given to explain about the illness, treatment received and whether clients were seen on first come first served)

Due to the fact that majority of the independent variables are categorical, generation of relevant dummy variables was important for the estimation and interpretation purposes. These are already presented in the methodology section

Before regression was run, Pearson Chi-square was calculated using STATA software to determine if there is any association between each of the independent variables to the dependent variable Answerability. Results indicated that all except three independent variables have significant positive association with the dependent variable Answerability, as presented below.

Table 18a: Chi-square test for Independent variables against Answerability

Sn	Independent variable	Variable attributes	Number of observations	Percent	Pearson chi2	p-value
1	Aware of existence of Boards and Committees?	Yes	108	25%	18.000	0.001
		No	324	75%		
2	Aware of meetings of health Boards and Committee?	Yes	67	16%	37.3175	0.001
		No	365	84%		
3	Knows how to lodge complaints?	Yes	86	20%	6.7049	0.013
		No	346	80%		
4	Have secondary level education or higher?	Yes	96	22%	0.2411	0.623
		No	336	78%		
4	Satisfied with waiting time?	Yes	168	39%	12.9670	0.001
		No	264	61%		
5	Satisfied with availability of laboratory services?	Yes	203	47%	1.1895	0.275
		No	229	53%		
6	Satisfied with cost of laboratory services?	Yes	232	54%	3.6497	0.056
		No	200	46%		
7	Satisfied with availability of medicine?	Yes	115	27%	9.6707	0.002
		No	317	73%		
8	Happy with the cost of medicine?	Yes	138	32%	0.7666	0.001
		No	294	68%		

Table **18b: Chi-square test for independent variables against Answerability(Continues)**

Sn	Independent variable	Variable attributes	Number of observations	Percent	Pearson chi2	p-value
9	Satisfied with cleanliness of health facilities?	Yes	270	63%	17.4240	0.381
		No	162	37%		
10	Satisfied with reception services?	Yes	230	53%	6.7134	0.001
		No	202	47%		
11	Satisfied with explanation given about diagnosis?	Yes	290	67%	23.8280	0.001
		No	142	33%		
12	Satisfied with confidentiality during consultations?	Yes	302	70%	28.6799	0.001
		No	130	30%		
13	Satisfied with explanation received about their illnesses?	Yes	297	69%	26.5484	0.001
		No	135	31%		
14	Satisfied with chance given to explain about their illnesses?	Yes	305	71%	34.6260	0.001
		No	127	29%		
15	Satisfied with treatment they received?	Yes	180	42%	9.6429	0.002
		No	252	58%		
16	Satisfied with clients seen on first come first served?	Yes	217	50%	8.8009	0.003
		No	215	50%		

Following the logistic estimation of the answerability model, it was found out that all independent variables had joint positive association with answerability, with varying magnitude of effect by individual independent variable. These results are presented as appendix H in this dissertation. For example, it was found out that those who know how to lodge complaints against unsatisfactory public health care services are 4.7 times more likely to perceive the health facility as answerable compared to their counterpart. A few more examples are presented in the following paragraph.

Respondents who were unhappy with the waiting time before they are served were 3.6 times more likely to find the public health care system not answerable compared to their counterparts. Those respondents who were satisfied with the treatment they were given were 3.9 times more likely to find the public health care system answerable than those who were not satisfied. Moreover, respondents who were not happy with the availability of medicine were twice as likely to find the public health care system not answerable than their counterparts. The final example is regarding reception services. Respondents who were dissatisfied with reception services at public health care facilities were 3 times more likely to find the public health care system not answerable than those who were satisfied.

In addition, marginal effect after logistic indicate that association and effect of three out of the thirteen independent variables was significant at 90 percent confidence interval as presented in table 20 below. Associations and effects of ability to lodge complaints was

significant at p = 0.044. Association and effect of waiting time to be served was significant at p = 0.076, and that of satisfaction with kind of treatment given was significant at p = 0.075.

Table 19: Logit Estimation Results for Determinants of Answerability

Variable	dy/dx	Std. Err.	z	P>|z|	[95% C.I.]	X
aware_board1	-0.000	0.015	-0.01	0.991	-0.030 .030	0.25
aware_meeting	-0.043	0.038	-1.12	0.262	-0.118 .032	0.155
Complaints*	0.0250	0.012	2.01	0.044	0.001 .049	0.199
S_waiting*	-0.036	0.020	-1.78	0.076	-0.076 .004	0.389
S_labservice	0.009	0.014	0.67	0.502	-0.018 .036	0.470
S_costlab	0.025	0.018	1.56	0.119	-0.007 .058	0.537
S_medicine	-0.017	0.019	-0.91	0.363	-0.055 .020	0.266
S_costmedic	0.015	0.012	1.28	0.201	-0.008 .039	0.319
S_cleanliness	0.007	0.017	0.38	0.707	-0.028 .041	0.625
S_reception	-0.028	0.017	-1.60	0.109	-0.061 .006	0.532
S_explanation	0.011	0.019	0.60	0.547	-0.026 .048	0.671
S_confidentiality	0.035	0.024	1.49	0.135	-0.011 .081	0.699
S_treatment*	0.031	0.017	1.78	0.075	-0.003 .066	0.444

Source: Author's calculations

4.9. Qualitative results for both transparency and answerability

A total of three in-depth interviews were conducted which involved two women and one man. This section presents the findings from these interviews, which are in terms of views based on interviewee's experience with accountability of public health care

service. The aim was to seek to understand in more details views and feelings of people regarding some of the variables in this study. These views were summarized and the best expressions are presented below.

4.9.1. Posting information on public notice boards

All three interviewees admit that there is some form of information posted on public noticeboards in public offices including health facilities. They also admit that information regarding annual plans, budgets, and progress reports is not posted at all. One interviewee appropriately put it this way: "I mean, when you go to the hospital you see a lot of posters, I mean about different things, prices for this and that but issues about those plans, budgets and those other things to tell the truth I have not seen them":

> *"Yaani ukienda hospitali utaona kwamba ni mabango yaani kuhusu mambo mbalimbali bei za hiki na kile, lakini kuhusu mambo ya mipango ya bajeti na hayo mambo mengine kusema ukweli sijayaona"*

On the same note, another interviewee was more direct on whether or not such information is relevant to citizens and whether or not it should be accessed by citizens. "…they are supposed to be true and transparent, not to conduct their business in secrecy, isn't it our money? It is not *magendo* (illegal business). Haven't you been given that money? Tell citizens, I have been given this money to do this and that, just like these citizens are saying this was budgeted for, donors paid for that, people are just guessing. They are now supposed to say, please, those who are saying so it is not like that, this

money is ours or it has been given by donors and put the whole truth in the open. Leaders like these are the ones we want…"

> *"...wanatakiwa kuwa wakweli na wawazi, siyo kufanya mambo kisiri, kwani si pesa zetu, siyo magendo. Kwani si umepewa hizo pesa? waambie wananchi, nimepewa hizi pesa kufanya hili na lile, kama hawa wananchi wanasema sema eti hizo pesa zimetolewa na serikali sijui zimetolewa na wafadhili, watu wanabuni buni tu. Sasa viongozi hapo ndiyo wanatakiwa watutoe mashaka sisi, waseme, jamani, hao wanaosema hivyo siyo hivyo, hizi pesa ni zetu, au zimetolewa na wafadhili na kuweka ukweli wote wazi. Viongozi wa hivyo ndio tunaowataka..."*

4.9.2. Perception about attitudes of public health workers

The male interviewee thinks that it is unfair to entirely condemn the attitude of all health works. He pointed out that sometimes it is the shortage of health workers and malfunctioning or absence of tools of work that are to blame although there are some particular services whose service providers are invariably irresponsible and negligent, such as the delivery section. The following are mixed views regarding whether or not service users are happy with attitudes of health workers

a) "…and those hospital attendants and doctors, we should sympathize with them. Their job is very difficult, there are not enough of them, working tools are not enough. We, sometimes we do not know, we think the doctors are mistreating us, we think nurses are mistreating us but problem is in those leaders we have elected, they fail to serve us. I think you understand there."

"...na wale wahudumu wa mahospitali pamoja na madaktari wahurumiwe. Kazi wanazozifanya ni ngumu, wao wenyewe hawatoshi, vifaa navyo havitoshi. Sisi wakati mwingine tunakuwa hatujui, tunaona kama hawa madaktari wanatutesa au hawa manesi wanatutesa kumbe ubovu uko kwenye hao viongozi tuliowachagua wanashindwa kutuhudumia sis. Nafikiri umenielewa hapo."

b) It is better in private hospital but in government hospital, you find one has labor pains, you climb up on the bed you are told to climb down, go that side, on your way you deliver by yourself. And when you have delivered by yourself, they slap and abuse you. "You ate those chips of yours out then you come here to disturb us and shout at us." Those are their words.

c) You arrive there, even if you have one glove short in your delivery kit they will not give it to you. You find syringe, cotton wool, I mean everything has to be complete otherwise they will not serve you even if you are very poor.

4.9.3. Corruption

All three interviewees affirmed that corruption is rampant in the public health care services. Below are some bits and pieces in interviewees' own words

a) "Corruption will not go away and will not go aware until the last day until the Judgment Day. Muhimbili, Temeke or hospitals for money, I mean, government hospitals, corruption will not end until the Judgment Day." *"Rushwa haiondoki*

na haitaondoka hadi siku ya mwisho mpaka kiama. Muhimbili, Temeke au hospitali za pesa ah za serikali, rushwa haiishi hadi siku ya mwisho"

b) "…Nurse, gloves which you came with for delivery may be finished even before you have delivered. You are told to go and buy some more. If you tell her that you do not have money, she says that I am going to borrow and when your relatives come you should claim my money from them. In the delivery room there is a cupboard, she opens it, take out some gloves, puts them on and starts to help you. Afterwards she follows you, give me my money. It is unclear whether Nurses brought that cupboard with them or if it is government's."

c) "They [your relatives] take you there you are in labor pain, they [nurses] check if you have brought all the items. If all the items are in your bag, they tell you go back to the reception and tell your relatives that you have been received but they should leave you with some money. You must have money, in your bag you must have money and delivery items."

d) "If you arrive there [for delivery] and you do not have the delivery kit you give them money and you deliver safely. They take your money telling you that they will have to buy the delivery kit from the shop outside the hospital compound but they will never leave the room and you will find that materials are available for you to deliver."

e) "If you want me to serve you nicely give me money for food first, I have not eaten. You can give her that Tshs 2000, and things [labor] are almost there, she disappears. You deliver on your own."

f) "If they want bribery, if bribery is good then they should not be paid by the government."

4.9.4. How to lodge complaints

All three interviewees had reservations with the current use of suggestion boxes at public health facilities. They believe that it is not working for citizens who are mistreated since the complainant is never consulted and does not get feedback regarding his/her issue. One interviewee suggests what she thinks is the best procedure for complaints. "This thing if it was been handled by the government, or, there, for example a patient has already been mistreated, the hospital would have established a special complaints committee so that immediately a patient is mistreated he/she reports to the committee there and then. The health worker who is reported to the committee is called and he/she is warned there and them, these would not be happening. But my father [referring to the interviewer friendly], even if you say you write your suggestions and put them in the suggestion box, the same health worker will pick it up if he/she sees they are negative to him he/she throws them away, will your suggestion reach the authorities?"

Hili jambo kama lingekuwa limeshikiliwa na serikali au pale kwa mfano mgonjwa kasha pewa manyanyaso, ingekuwa pale hospitali kuna kamati maalumu pale pale mtu akinyanyasika nenda pale katoe malalamiko yako na anaitwa yule mtu pale pale anakanywa wala yasingekuwa yanatokea haya. Lakini baba yangu, hata kama ukisema unandike maoni ukaingize kule keshaona yule anachukua akiona baya kesha chana kasha tupa maoni yako yatafika?

4.9.5. Users satisfaction with quality of care

Interviewees narrated a lot of experiences related to poor or lack of response of health workers on both emergencies and routine procedures. One interviewee narrated the case of her son who died in Muhimbili hospital after being transferred from Temeke Hospital for blood transfusion. He was rushed by ambulance from Temeke Hospital but upon arrival at Muhimbili at 5 PM no procedure was performed until he died at 7:55 PM in spite of her constant plea with nurses and doctors to save his son's life. Even after he died nobody seemed to be touched by the fact that a human being lost life as a result of such negligent circumstances.

"I myself have once been pregnant, when I was pregnant, now that baby died in my stomach while I usually go for ante natal clinic there. You see, now, they check me up but they did not tell me that this baby inside is not breathing or what. They tried to suck it out, the baby is not coming. You see, then they realized this woman should go for cesarean. But since morning until evening I did not get consensus there, to say this woman will undergo cesarean. My relatives realized that they will lose both myself and the baby, they had to take me out of there to the private hospital for cesarean. They found out that there was a ruptured vein in my stomach, they removed two bottles of blood.

Had I continued to wait there, would I have been cured? So, what was their intention, was it not for me to die?"

Regarding routine procedures, another interviewee puts it more appropriately. "For example, a drip is just finished, come remove it. She tells you leave him first. He can stay with it from morning to afternoon, drip is finished and it is not removed he stays with the syringe in his body like that."

> *"Kwa mfano drip ndo imeshaisha, njoo basi umchomoe. Anakuambia muache kwanza. Anaweza akakaa nayo asubuhi mpaka mchana, drip haina kazi na kuchomolewa haichomolewi sindano anakaa nayo vile vile mwilini.*

4.10. Results from analysis of policy documents

4.10.1. The Constitution of the United Republic of Tanzania

Article 14 of the United republic of Tanzania (2005 Swahili Edition) provides for every person the right to live get protection from the state according to the law. This is a fundamental right enshrined in our constitution to protect and provide for every life. It follows that lack of accountability in the delivery of health care services is a breach of the Constitution and may lead to loss or endangering of lives.

Article 18.b provides for the right for every citizen to seek, receive, and disseminate information regardless of state boundaries. Article 18.d further emphasizes that every

citizen has the right to be given information all the time about different important events for life and civic and other important events for community. These rights are important foundations upon which access to information should be implemented. In view of this study, citizens should use these Constitutional rights to access and demand for information regarding health plans, budgets, expenditures and progress reports.

Article 21.1 provides for every citizens to participate in the governance of the country either directly or through an elected representative. Article 21.2 provides for the right and freedom of every citizen to fully participate in reaching a decision about issues relating to him/her, his/her life or those relating to the Nation. In relation to this study, these specific rights lay foundation for citizens to participate in planning, implementation and evaluation of health care delivery programmes in the level where they access health care and at higher levels.

Article 27.1 provides for responsibility to every citizen to protect natural resources of the United Republic, properties belonging to State Authorities, communal properties and also to have respect to properties belonging to other individuals. Article 27.2 provides for responsibility of every citizen to protect and care for State and joint properties, to fight all forms of misuse and abuse, and to run the State economy careful, as people who make decisions about the future of their Nation. These rights which citizen might take advantage of and fully participate in decision making at all levels of health system to

ensure that public resources in the health system are efficiently and effectively planned and utilized

Article 26.1 provides for responsibility for every citizen to abide and respect the Constitution and laws of the United Republic of Tanzania. Article26.2 further provides for the right of every citizen, through legal procedures, to take legal action to ensure protection of the Constitution and laws of the country. It follows that health service providers violate rights of citizens as stipulated in the Constitution of the United Republic of Tanzania, if they do not supply accountability related information to citizens, they do not involve citizen in all planning, implementation and monitoring processes or if they are proved to have misused and abused public resources. It also follows that the Constitution of the United Republic of Tanzania empowers every citizen to take legal action against violation of the Constitution.

4.10.2 Local Government (District Authorities) Act, 1982 (Revised Edition 2000)

Article 111.2 of the Act, among other things, gives a local government authority to take all such measures as in its opinion are necessary, desirable, conducive, or expedient for the furtherance and enhancement of the health, education, and the social, cultural and recreational life of the people. As per this article, enhancement of people's health is one of the roles and responsibilities of local government authorities.

Article 111A (1) states the objectives of the local government authorities, among others, to promote and ensure democratic participation in, and control of decision-making by the people concerned. Also to establish and maintain reliable sources of revenue and other resources in order to enable Local Government Authorities perform their functions effectively and to enhance financial accountability of local government authorities, their members and employees.

Article 111A (2) demands that Local Government Authorities provide their services in an efficient and cost-effective manner and foster cooperation with civic groups and other persons or authorities. This article provides for space for citizens individually or in organized groups to participate in the affairs of health care planning, budgeting and monitoring.

Article 67.1 declares that every meeting of the district council is open to the public and the press. Article 69 further declares that minutes of the proceedings of a district council shall be open to inspection by members at all reasonable times, and by any member of the public at such time and under such arrangements as may be sanctioned by the Chairman, and any person may obtain an extract from the minutes upon payment of such fee as may be specified by the district council. In the opinion of the researcher, these two articles give every citizen the right to access any information relating to annual health plans, budgets, and implementation progress reports since they are discussed by the district council.

Article 141 states that a village assembly is the supreme authority on all matters of general policy making in relation to the affairs of the village as such, and shall be responsible for the election of the village council and the removal from the council of any or all of the members of the council, and for the performance of any other functions conferred upon it by any written law. Article 142.3 further gives the village council powers to do all such acts and things as appear to it to be necessary, advantageous or convenient for or in connection with the carrying out of its functions or to be incidental or conducive to their proper discharge. These two articles are the primary and entry point for every citizen to call to account any public officer as all public services ultimately impact citizens at village level. Health care performance and accountability should have therefore being one of the important issues in the affairs of both the village assembly and council.

4.10.3. The Local Government Service Act, 1982 (Revised Edition 2000)

Article 13 of this Act states that local government employees are accountable to the Local Government Authorities and that any employee who neglects to comply with orders for him/her to account to the Authority commits an offence and on conviction is liable to a fine not exceeding two thousand shillings or to imprisonment for a term not exceeding six months or to both that fine and imprisonment. Article 14C (b) further gives the Council authority to take disciplinary action in respect of officers it employs and Regional Commissioner shall be the final appellate authority.

4.10.4 The Local Government Finances Act, 1982 (Revised Edition 2000)

Article 43 gives every local government authoritative the mandate to pass a detailed annual budget of the estimates of the amounts respectively expected to be received and expected to be disbursed by the authority during the financial year and whenever circumstances so require, an authority may pass a supplementary budget in any financial year.

Article 44 states that the Regional Commissioner may authorize in writing any person to have access to the record including books of accounts of a local government authority and submit a report to the Regional Commissioner in connection with the records.

Article 49 states that every local government authority shall at its own offices and in such other manner as may be directed by the Regional Commissioner publish within its area the annual balance sheet and statement of abstract; and any report on the accounts made and signed by the auditor. It further states that these documents shall be published within six months after the close of the financial year to which the accounts relate or within six months of the receipt of the report of the auditor.

4.10.5. Health Sector Strategic Plan III (2009 – 2015)

The Health Sector Strategic Plan III (2009 -2015) declares that decision making should take place as close as possible to the place of service delivery. It intends to achieve this through strengthening of interactions between communities and health service providers through the health facility committees on decision making regarding the use of generated funds. It is the right decision to strengthen health facilities committees since available literature already suggest that members of these committees are not accountable to the communities they purport to represent.

4.10.6. The National Health Policy 2007

The National Health Policy of 2007 is clear about citizen participation in the governance of health services at all levels and that every dispensary must have a participatory annual health plan which all citizens must participate in its implementation. It puts responsibility on citizens to protect and care for resources at public health facilities. It also demands for both village and ward health committees to involve all citizens in decision making regarding improvement and management of health services. The policy gives responsibility to the district council to ensure quality of health services through information dissemination, planning, coordination, implementation, monitoring and evaluation of health services in collaboration with communities and other stakeholders at all levels of the district

4.10.7. The District Council (Council Health Service Board Establishment) Instrument Act, 2001

This is a legal instrument to guide the establishment and functions of district health boards and health governing committees in Tanzania. It provides a general framework out of which every council is expected to enact its own bylaw for the establishment and functioning of health board and health facility governing committees. The instruments providers for detailed roles and responsibilities of both health boards and health facility governing committees. The only shortcoming of this Act is that it directs accountability of members and committees upward to the council and none to the communities they represent.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This chapter presents discussion of results of the different components that addressed the main objective of the study, which was to assess the downward accountability of public health care system of Temeke Municipal Council. Specifically, it intended to assess transparency, answerability, and the extent to which existing policy and legislations either promote or hinder accountability of district health care to citizens. In addition, it also intended to assess magnitude and direction of association between the dependent

variables of transparency and answerability with the explanatory variables individually and jointly.

5.2. Transparency

This section tries to discuss findings related to whether or not the public health care system of Temeke Municipal Council is transparent to its service users or not by using results of the assessment of flow of information from health facilities to citizens. It is the researcher's view that there is Transparency in the delivery of health care services if at least 60% of information is readily accessible by the citizens. The degree of transparency can be either demand induced or supply related. Demand induced transparency is associated with the provision of the health related information by the providers in reaction to the demand of the citizens. However, supply related factors are associated with the pro-activeness of the health service providers to give out all the information without being asked by the citizens. The information referred in this study is that related to health care service planning, budgeting and reporting.

Chapter four of this study has provided strong evidence that legislation and policies in Tanzania do provide for framework for government officials to be transparent and for citizens to demand information at all levels of the government. However, both supply and demand of information from public health facilities is not happening. It is the view of the researcher that either these policies are unknown to citizens and service providers,

or citizens lack assertiveness altogether. The service providers may either be capitalizing on the ignorance of citizens or they are ignorant of the law themselves.

5.2.1 Supply related indicators

On average, only 30 percent of respondents consider the public health care system of Temeke Municipal Council transparent hence public health care system of Temeke Municipal Council is not transparent to its service users. Specifically, only 2 percent of citizens in Temeke have ever seen a copy of council's audit report and 13 percent believe that health budgets are posted publicly at health facilities. Fjeldstad (2004) reports that only 3 percent of citizens had seen audited statements of councils' expenditures and 4 percent sectors financial allocations.

As indicated in chapter four, policies and legislations in Tanzania require for information regarding plans and finances of local government authorities to be posted publicly at various levels. Although only 67 percent of public health facilities in Temeke Municipal Council do have public notice boards, most information was found to be posted on walls indicating that absence of noticeboards should not be an excuse for posting the requisite information publicly.

Although 72 percent of respondents have seen health plans posted publicly at health facilities, the researcher thinks it is an anomaly. It might have something to do with their abilities to distinguish proper annual plan from information such as schedules of

vaccination services given their unfamiliarity with a public plan. Another reason could lie in the fact that the majority of respondents are less educated and have no experience in public planning. In addition, research by Mushi et al (2005) found that public officials are reluctant to share written information with the public on the assumption that people would not read it.

Consequently, 82 percent of respondents in the household survey indicated that they usually find information posted publicly in health facilities. However, observation of information on 24 health facilities did find plenty of information posted publicly only regarding health promotion and education, announcements and pricing for various health care services. This type of information is important for promoting health and healthy lifestyles but does not lead to transparency since it is not civic in nature. This observation is also supported by in-depth interview respondents who indicated that information about plans and budgets is at all not posted publicly

Secondary education and above was found to have significant positive influence on the perception of transparency. This relates well with the fact that about 74 percent has education below secondary school and only 39 percent of respondents do understand information posted publicly at health facilities. To this effect, participation in the planning and implementation processes was also found to have significant positive association with the perception that public health care system is transparent.

Reasons for not at all posting these types of information publicly are given are not clear from health providers point of view. Respondents believe that health providers do not share this information because they do not respect and value citizens especially when they know that no action will be taken against them if they do not supply information to citizens. Respondents believe that health workers with-hold this type of information deliberately to cover up any abuses or misuses of public funds. Invariably, the government of Tanzania acknowledges that there are weaknesses in the flow of information both downward and upward within the council (URT, 2007e).

5.2.2 Demand related indicators

Despite the fact that the health facility managements do not provide much information to the citizens, it appears that there is little pressure from the citizen demanding such information. Large share of respondents (99 percent) reported to have never demanded information regarding health plans, budgets, and implementation reports from the health facility management. This proportion is lower than that reported by the government of Tanzania (URT, 2007a) that 7 percent of people in Dar es Salaam region request information from the district level, 14 and 10 percent from ward and *mtaa* respectively.

Lack of awareness about their rights and confidence were cited by respondents as reasons for not demanding information. They also believe that health workers do not value and respect citizens, which mean if they demand information it will not be given to

them anyway. The fact that action is not taken against those service providers who deny information to citizens is a demotivating factor for citizens to demand it.

5.3 Answerability

The objective for this section was to determine proportions of citizens perceiving the public health care system of Temeke Municipal Council to be answerability to service users. Answerability is claimed to exist if at least 60% of Temeke residents (represented by the sample) are satisfied with the performance of the health workers, their participation in planning, absence of unofficial fees, and satisfaction with quality of public health care services. Only 34 percent average of 28 indicators used to measure answerability indicates the said satisfaction, hence the public health care system of Temeke Municipal Council is not answerable to its service users.

5.3.1 Health facility governing committees

As presented in chapter six, only a minute proportion of citizens in Temeke Municipal council are aware of the existence and functions of health board, facility governing committees and ward health committee. Consequently they are unaware of members of these committees. In a similar study in Tanzania, Boon (2007) found out that health committees and board are unknown to ordinary people and are not functioning to the extent planned and wished. She stated reasons to be due to selection of members being done by the government, limited knowledge of their roles, being accountable to the

government rather than the communities they claim to represent, and lack of mechanisms for citizens to hold them to account.

5.3.2. Citizen participation

Given the lack of access to information, the low awareness of health governing boards and committees, citizen representation through committees does not automatically translate into citizen participation. As required by law, direct participation should also be encouraged. However, a clear majority (95 percent) of respondents have not directly participated in planning for health care services in Temeke Municipal Council. The essence of participation is aptly captured by Julius Nyerere (1973) by asserting that;

> *"sovereignty of the people is the most important because the good of the people is the only legitimate purpose of all national activities, and only the people themselves can say what is to their good (p.35). People must be allowed to make their own decisions, and therefore their own mistakes. We can advice and warn, but if we try to run them we are destroying them (p.8)."*

Views of the People (URT, 2007a) reports that 52 percent of people in Dar es Salaam region express that participation in public affairs make a difference and 69 percent believe that people should be more involved in decision making about public affairs.

5.3.3. Complaints

Large share of respondents (83 percent) reported that people complain about quality of public health care in Temeke Municipal Council. The intention of this question was to

separate feeling of dissatisfaction from steps taken against it. When such a majority of service users hold such a strong negative view against health care it can be interpreted as an indicator of lack of answerability of the service providers. But it can also be interpreted as an indicator of increased awareness of citizens regarding their health care rights.

Knowledge of how to lodge complaints among the people of Temeke Municipal Council is only 23 percent. Whether or not one knows how to lodge complaints against unsatisfactory public health care services was found to have strong positive association with the perception that public health care is answerable to its users ($p<0.013$). Results from the in-depth interview indicated that people have reservations with the current use of suggestion box as the only means for one to lodge complaint. Availability of a suggestion box was one of the items checked during the observation of information in public health facilities.

Ten out of a total of 24 health facilities visited did not have suggestion boxes but even the majority of the existing ones were found not functional. The researcher deliberately peeped into all the available suggestion boxes and found thick cobwebs and some boxes were not locked at all while others were only locked with one padlock as opposed to two. Where a suggestion box was locked with two padlocks the researcher inquired for reasons from the facility in-charge. Explanation given was that one padlock is opened by

the facility in-charge and another by the chair of the facility committee to ensure that facility staff do not temper with complaints that are directed to them.

Nonetheless, citizens believe that the mechanism for suggestion boxes is not working for citizens who are mistreated since the complainant is never consulted and does not get feedback regarding his/her issue. This is to say that there is no functioning and trusted complaints mechanism at health facility level. A study by Mamdani and Bangser (2004) concluded that reliable mechanisms for raising concerns and for channeling them to the district level for action are not in place. This may lead to possible despair if people who have reasons to complain about the quality of health care services cannot do so because official mechanisms do not exist.

5.3.4. Level of satisfaction with public health care services

As presented in chapter four, this study used a total of 28 different indicators to measure peoples' satisfaction with quality of public health care services. Generally, 34 percent average of people in Temeke Municipality is dissatisfied with quality of health cares services. This proportion compares closely with the national proportion of 32 percent (URT, 2007a) and 38 percent from a study of six district councils (Braathen et al, 2005).

Some specific indicators of this study regarding citizen satisfaction are worth comparing with those of Dar es Salaam as reported in the Views of the People (URT, 2008a). Proportion of people who are satisfied with public health care services from the Views of People survey are presented for comparative purposes.

Table 20: Service quality satisfaction, Temeke and Dar es Salaam, percent

Indicator	Temeke Municipality	Dar es Salaam
Time waiting to be served	39	45
Availability of medicine	27	50
Cost of medicine	32	38
Cleanliness of environment	63	90
Attitude of service providers	34	75

Proportions for some indicators from this study as presented in table 20 are significantly different from those of Dar es Salaam while others are not. One explanation of the differences could be in the nature of both studies which is about perceptions of people. Perceptions are sometimes motivated by different feelings and circumstances over time. Another explanation could be that people's perception of quality of health care service in Temeke Municipal Council as poorer compared to other councils in the same region. It could also be interpreted that people's satisfaction of public health care services in Dar es Salaam region has deteriorated from 2007 to 2009.

Results of the in-depth interviews give a number of ways in which quality of public health care is not satisfactory to people. Interviewees reported that problems emanate from either the attitude of health workers or inadequate or absence of health supplies and equipment. The latter calls for understanding from the service users to hold accountable the elected leaders to ensure that health workers have all the necessary requirements for the delivery of quality services. The former calls for adjustment of attitude by health workers.

5.3.5. Corruption

When people have strong conviction that corruption cannot end in the health system and that the government is unable to fight it the situation turns into crisis. Corruption in the health care delivery is a systemic feature posing major problem in the lives and quality of care. This study presents that 72 percent of respondents believe that public health care system in Temeke Municipal Council is corrupt. Despite the magnitude of unofficial payment, people do not believe that corruption will ever go away in the public health care systems, as affirmed by one interviewee.

This finding is supported by Muhondwa et al (2008) that 82 percent of people in Dar es Salaam and Coast region believe that public health care systems are corrupt. According to the Views of the People (URT, 2007a), only 41 percent of people in Dar es Salaam region believe that the government's actions against corruption are effective.

Corruption is a major indicator of poor quality of public health care. It denies people the right to life, quality health status, and care. Corruption in the health care leads to health users' dissatisfaction not only with services but with their government as well. It potentially leads to abuse and misuse of power and public financial resources. Fighting corruption is therefore inevitable.

5.3.6. Association between independent and dependent variables

This section discusses the significant results of multiple logistic regressions for the independent variables transparency and answerability.

5.3.6.1. Transparency

The most significant factors on individual perception of the prevalence of transparency in the system were only two. It was found that people with at least form four secondary education or above are more likely to perceive the system to be transparent than their counterparts, who have less education ($p = 0.051$). Respondents who participate in the annual planning and budgeting for the health facility have higher probability of perceiving the system to be more transparent than their counterpart ($p = 0.001$).

These findings tally with those found in the previous section of this chapter. The majority of Temeke residents has less than secondary education and do not participate in public health care planning. As a result, the majority reported not to understand the

information posted on the boards and not to have ever demanded any information from the health facility authority.

Policy implication of these finding is that education of the citizens is one of the prerequisite in holding the system accountable. If a reasonable number of citizens is given adequate education (at least secondary), then there is a greater possibility of the authorities becoming more transparent. This share of elites will have higher probability of understanding their rights, know the proper way of demanding what they should have been given and hence hold the authority more accountable. This is as opposed to the current situation where you have a very large share (approximately 80 percent) without at least secondary education.

Similarly, if people participate in planning, implementation and monitoring of health care services they are more likely to hold the system accountable. Legal and policy framework in Tanzania set the foundation for citizen participation at all levels of governance. If these policies are effectively implemented, people will not only realize their civic rights but increase their ability to hold the health care system accountable, hence quality health care services.

5.3.6.2 Answerability

From the estimation, it was found that those who know how to lodge complaints against unsatisfactory health services are significantly likely to perceive the health facility

authority as answerable compared to their counterpart ($p = 0.044$). Results of this study and others done before that there are complaints against public health care services. This supports the call for efficient and effective mechanism for citizens to express their opinions regarding quality of health care service.

Also it was found that staying longer time waiting to be served is a significant attribute against answerability ($p = 0.076$). Those who were unhappy with the waiting time are more likely to find the system not answerable compared to those who were happy with the waiting time. The researcher is aware that there are many reasons for delay in getting services after arriving at health facility, one of them including shortage of qualified health workers. However, this estimation results indicate that if the government intends to improve perception of people about public health care services then it must find ways and means to deal with long waiting time for one to be served hence quality health care.

Satisfaction with the treatment given by the health services providers was found to be another significant factor to the respondents' perception on the answerability of the facilities ($p = 0.075$). Whenever one visits the public health facility whether as a patient or accompanying one, he/she expects to be satisfied with the treatment he or she receives. There are numerous factors compounding perception of satisfaction with the treatment. Some of them are affordability, attitude of providers, and availability of medicine and laboratory tests.

CHAPTER SIX: CONCLUSION AND ECOMMENDATIONS

10.1 CONCLUSION

Many indicators were used in this study to measure transparency and answerability which are two dependent variables chosen by the researcher to study accountability of public health care of Temeke Municipal Council. Average percentage scores for the two measures of accountability in this study are below the expectations of the researcher. Interestingly, some indicators were found to have significant association and affect with transparency and answerability hence a requisite condition for accountability.

The health care system is likely to be perceived as transparent if citizens are educated to at least form four secondary level and that they participate in health care planning and management. On the other hand the public health care system is likely to be perceived answerable if less time is spent by service users to wait to be served, if service users are satisfied treatment they receive, and if they are able to complain in case of dissatisfaction with health care services. Unfortunately proportions for these five indicators were found to be generally low.

Analysis of policy and legal documents indicate clearly that the legal framework in Tanzania for public health care system to be accountable to service users is in place. The

framework also gives citizens as service users enough civic rights to demand for accountability of public health care system. However, research findings indicate that both supply and demand sides are not working, hence good policies and legal framework not translated into practice.

Based on these results, therefore, the researcher concludes that public health care system of Temeke Municipal Council is generally not accountable to its service users, despite existing conducive policies and laws. This implies the civic rights of citizens are compromised and there could be possibility of misuse and abuse of public resources by the public health care system. It is however not clear if service providers are punished for not being accountable and transparent to service users. Consequently, peoples' health status and quality of health care are compromised.

10.2 RECOMMENDATIONS

The government of Tanzania has just embarked on the implementation of the third Health Sector Strategic Plan, through which improvement of health care governance and citizen participation is promised. Problems relating to the establishment and functioning of these health committees and boards should be addressed as a matter of urgency to achieve the intended aims

Citizen participation in public health care is very limited. This undermines legitimate civic right of users to determine priorities and ensure good governance of resources in health care delivery. Low or lack of participation leads to citizen's dissatisfaction with health care services and mistrust of health care providers. Allegations of misuse and abuse of public funds become difficult to either dismiss or justify. Local Government authorities should devise mechanisms for citizens to participate fully in decision making and performance monitoring

Clearly, legislation and the Constitution of the United Republic of Tanzania gives adequate rights for citizens to access public information, participate in public affairs, and hold public officials to account. However, as justified by results of this study, the extent to which these legal and constitutional mandates are enjoyed by most citizens is far from certain. Translating the existing legal and constitutional rights into bureaucratic mandates and operational practice remains a key challenge to be addressed by both central and local governments.

Public health facilities have publicly posted a lot of information regarding health promotion and education. However information regarding public health facility plans, budgets and progress reports are not publicly posted at all. It is not entirely clear as to why the former is possible while the later was not posted. All public health facilities should publicly post all information regarding annual facility plans, budgets, incomes, expenditures, and progress reports. Health board and committee members should be a

true representation of health care service users and ensure that information is posted and complaints are responded to publicly.

In addition, public health facility administration and health board and committees should jointly devise effective mechanisms of providing feedback to service users on issues of health worker performance, flow of drugs, allocation and use of money, and other priorities as defined jointly by health users and providers. They should also allow independent civic groups to monitor the performance of each public health facility. Finally, they should value and respect service users as a way to encourage them to participate and own services.

A majority of people have complaints about quality of public health care yet only about a third of them know how to lodge complaints. Existing mechanisms for lodging complaints such as the use of suggestion boxes are doubted and not functioning. This study suggests establishment of participatory and transparent complaints mechanisms by local government authorities to enable for improvement of quality of health care delivery. The mechanism should clearly state and communicate to the public about who can make a complaint, what can be complained about, how are complaints made, how and when are complaints responded to, and compensation for harm if done. The researcher believes that the below suggestion from an in-depth interviewee is worth reiterating.

"This thing if it was being handled by the government, or, a patient has already been mistreated, the hospital would have established a special complaints committee so that immediately a patient is mistreated he/she reports to the committee there and then. The health worker who is reported to the committee is called and he/she is warned there and then, these would not be happening. But my father [referring to the interviewer friendly], even if you say you write your suggestions and put them in the suggestion box, the same health worker will pick it up if he/she sees they are negative to him he/she throws them away, will your suggestion reach to the authorities?"

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