

Local Government Reform Programme and Health Service Delivery in Kasulu District, Tanzania

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Abstract

The study investigates how the local government reforms shaped health service delivery in Kasulu District council. Firstly, the study intended to find out how reforms assisted management of quality and capacity to offer health services in Kasulu. Secondly, the study examined the challenges to offer adequate and quality health services in Kasulu District. The other objective was to assess how health service reform attracted community involvement in planning and implementation of health services in Kasulu. The expo-facto descriptive design used to explore changes after the health service reforms in Kasulu. Whereby, the interest was to know both challenge and improvement encountered through the reforms undertaken. The study involved () respondents as a sample to represent the whole population in the study area. A structured questionnaire was administered to health service officers and heads of household in order to fill in questions. The questionnaire analyzed through frequencies and mean which were presented in percentages, charts as well as figures. The percentage distribution formed a basis for conclusions. It was revealed that there were inadequate health facilities and staffs; this led into poor service provision. For instance, still there is good number of people trust traditional healers than doctors. This is due to poor services offered such as unsuccessful treatment, long waiting and inadequate expertise. The Local Government Reform Programme (LGRP) was formulated and implemented by the Tanzania Government with an intention of addressing problems which constrained the performance of the local government authorities such as the human resource capacity and management being weak and this seriously constrained performance by Local Government Authorities, weak leadership and poor management of the councils, shortage of properly qualified, disciplined and committed personnel, shortage of revenue due to narrow tax base, over-employment within the Councils and lack of transparency and accountability in the conduct of Councils' business. The study concludes that effectiveness of health service delivery is mainly determined by both local government system and the community involvement. That is local government policy reforms, critical resources management and full engaged community. From which the community can play their role to promote a dynamic health delivery environment.

Keywords: Service delivery, Local Government Reform Programme, Accountability and Local Government Authorities

Abbreviations

ESRF	Economic and Social Research Foundation
HIPC	Highly Indebted Poor Country
HSSP	Health Sector Strategic Plan,
O&OD	Opportunities, Obstacles to Development
PEDP	Primary Education Development Plan
CHMT	Council Health Management Team
LGAs	Local Government Authorities
LGs	Local Government system
LGRP	Local Government Reform Programme
MCH	Maternal and Child Health
PMO-RALG	Prime Ministers Office, Regional Administration and Local Government.
PSRP	Public Service Reform Programme .
TASAF	Tanzania Social Action Fund
TBAs	Traditional Birth Attendants
URT	United Republic of Tanzania

1.0 INTRODUCTION.

1.1 Background information.

Generally the history of local government can be traced back 1961, there were only 17 Councils. But, the number increased up to 68 councils in 1972. The councils introduced with the intention to decentralize the

government and promote democracy and address overall development. Since then, the government identified three key developmental enemies these were poverty, illiteracy and diseases. Hence, structures of implementation such as decentralized institutions were devised at various levels to fight the above enemies. The central government, local governments and other institutions such as religious sects participated in the provision of social services, such as education and health care (URT, 2003). The policies and strategies were directed towards improving living standards of the people through provisioning of better or improved social services such as education, health services to mention but few. It was observed that it was not possible for Central Government to fully provide such services to the public, hence the need for introducing Local Government Authorities (LGA's) which was thought to be closer to the people.

Later in 1972 local authorities were abolished and replaced by a direct Central Government rule, in a policy popularly known as "decentralization". As per PMO's report at the time of their abolition, there were 66 rural/district Councils and 15 urban Councils in Tanzania. The government experienced challenges such as poor participation of community in resources management. This led into a new decentralization program in 1972-1984, when the government switched from partnership to direct management of the development process and provision of social services. A number of committees were established in the villages, wards, districts and regions, as vehicles for people's participation and Regions became the primary drivers of rural development planning and implementation. The Government of Tanzania undertook various initiatives and reforms to attain sustainable social and economic development. Among other initiative and reform processes included the Local Government Reform Program that intended to help the implement of poverty reduction strategy across the country (National Poverty Reduction Strategy or MKUKUTA). The principal objective of the Local Government Reform Programme was to restructure local government authorities so that they can respond more effectively and efficiently to identify local priorities in a sustainable manner. This includes specific objectives, such as 'improve quality, access and equitable delivery of public services, particularly to the poor'. LGRP is only one of several determinants for eventual improvements in service delivery performance. The sector programmes based on donor funded basket programmes in combination with central government resources released through the Highly Indebted Poor Country (HIPC) debt relief scheme, are also important. This is particularly seen in the Primary Education Development Plan (PEDP) and in health services. The LGRP aims to transfer duties and financial resources to local government levels. Local government authorities are thought to be in a better position to identify people's needs and to encourage citizens' participation in democratic governance to ensure the appropriate form and level of public services. (Odd- Helge, Einar and Amon; 2007)

With respect to LGRP, Individuals, households and communities are key actors in health and development for any nation. Efforts should therefore be made to involve all actors in planning and implementation of development programmes so as to ensure ownership and sustainability. Empowering households and communities with knowledge and skills will make them better grass-root partners of health and development (WHO 2002). There has an effort directed towards ensuring that people at grass root level are the main stakeholders in decision making. This was much emphasized during decentralization and now LGRP. The organization and management of effective health systems is important to ensure that all citizens have access to basic health services. According to WHO, health systems comprise all the organizations, institutions and the resources that are devoted to producing health actions for improving the health of the community. It is being proved that, if people's health good, there's high likeness for them being involved in production necessary to improving their welfare or living standards.

A good system should respond well to the expectations of all people without discrimination. Health systems developed by many countries responded to the need of protecting health and treatment of diseases affecting the population. Therefore, the study intends to whether or not LGRP has brought in difference in health service provision as contributing aspect in reducing both income and non-income poverty. In fact, Local authorities have three major sources of funding: own revenues, central government transfer and development aid (Fjeldstad, 2003). In addition, user charges and various forms of self-help activities contribute to the running and maintenance of health services facilities. Although the data on the extent of user charges are self help activities is not available, some studies from the late 1990s indicate that these contributions are significant and increasing yearly (Cooksey & Mmuya 1997; Semboja & Therkildsen 1995)

On the other hand, Community expect to understand good governance practiced when participate in planning and implementation of development activities. This gives the authority of deciding and implementing their activities under existing laws and policies, corruption being reduced and the village governments undertake its activities democratically including people's participation from planning to implementation stage (Kinemo, 2004). It was/is expected that with LGRP there would be transparency and accountability on the side of the public officials pertaining to inflow and outflow of funds.

It has been noted that, one of the pertinent objectives of LGRP is to facilitate LGAs to enable them deliver sufficient, reliable, predictable and quality service delivery to the majority of the citizens in the country. This is not only strategically important for LGRP but the main raison – detre for the Government to devolve power,

authority and responsibility to LGAs and below improving service delivery in order to reduce poverty is the ultimate goal of the LGR (HSSP, 2003). The service delivery function involves a decentralization of public services to bring efficient, predictable and reliable services closer to the end user and to ensure the quantity and quality of these services (ibid).

Human capacity building has been addressed across a wide range of Government reform programmes supported by development partners, notably the Public Service Reform Programme (PSRP) and LGRP. The LGRP has aimed at increasing the quality, access and equitable delivery of health service at local government level, to improve qualification of civil servants in LGAs. Some progress to be made in the competence and service delivery role of local governments such as qualified officers to be recruited and received on – the -job training (Ngware, 2005). At the present reform, capacity building is the most immediate concern and has focused on what is termed as 'service delivery reform capacity'. Other areas of concern in the inception phase have been service provision structure; services needs priorities, and councils' poverty orientation.

This goes hand in hand with human capacity building, from which it fall into the hands of professional capacity in order to fetch the know-how and create participatory planning system. I.e. involving communities in decision process on whether it touches their wellbeing or areas of interest. As opposed to the centralization era whereby everything was decided from the center and then superimposed to grass root for implementation. It is expected that while the reform appears to have an immediate effect on the professional capacity, there are other and more complex sets of factors that influence the popular capacity (i.e. the participatory planning system) (Ngware, 2005). Among other factors hindering participatory system includes: Shortage of funds, inadequate time and manpower resources to administer the system. Also the system was criticized on ground that it is time consuming. But all in all international institutions have been putting much emphasis on adopting participatory systems in whatever development projects that is expected to introduce in particular locality.

A common denominator in all the case councils was lack o professional human resources. Funding for investments had improved in recent years due to increased conditional grants for health and education (as a result of the HIPC arrangement) and schemes to support self-help initiatives (like TASAF). However, there was no sufficient funding to re-employ the required personnel for example nurses and teachers. Human resources are noted to be a constraint to enhance district and local level health services; there is a documented shortage of both number and skills in district health staff. Human resource issues need to be addressed rationally, it is worth focusing on the specific human resource needs at district and local level (HSSP, 2003). Activities targeting human resource must focus specifically on changes needed to improve quality of health services delivery.

In order to achieve a successful poverty reduction policy in 1984 the Local Government Authorities were reintroduced to improve performance. However, the expectation was not realized due to a number of reasons. The government anticipated to improve performance in service delivery as well as development initiatives through broad-based public involvement was not being achieved as anticipated. Several studies were carried out to establish reasons for this failure, and the following were identified as being some of the underlying reasons: The human resource capacity and management was weak and this seriously constrained performance by Local Government Authorities, weak leadership and poor management of the councils, shortage of properly qualified, disciplined and committed personnel, shortage of revenue due to narrow tax base, over-employment within the Councils, lack of transparency and accountability in the conduct of Councils' business. The challenges led into poor quality, limited access and inadequate health delivery in various councils including Kasulu.

1.2 Problem statement.

Tanzania has been undergoing various reforms in order to offer quality and adequate health services among the community. Among other reforms, the government endeavors to promote services offered through Local Government Reforms Program. Whereby, issues like cost effective organization structure and accountability need to be addressed under local government. Also the government intended to prepare community participation in various stages such as planning and implementation. From which the government expected to ensure improved quality, accessibility and ensuring sustainability of the health services especially to poor communities. However, The Second Health Sector Strategic Plan (HSSP 2003) revealed that above all the efforts and reforms taken to strengthen policies or strategies; still there are complains on low level of health delivery including Kasulu district council. Thus, this situation led into increase of morbidity rate in rural and urban as well as chronic diseases. Therefore, this research intended to study how the Local Government Reform Program facilitated health service delivery in Kasulu.

1.3 Research objectives.

In order to achieve its plan, the study was guided by three objectives:

- To find out how reforms assisted management of quality and capacity to offer health services in Kasulu District.
- Examine challenges towards implementation of health service delivery Kasulu District.
- Assess the impact of Local Government Reforms to attract community involvement in various levels of health services management in Kasulu District.

3.0 STUDY METHODOLOGY

The study deployed expo-facto descriptive design to describe health service strategies. Likewise, to uncover new facts related on government efforts and reforms towards health service delivery (Polit&Hungler, 1999). This involves the collection of data that provides an account or description of individuals, groups or situations in a natural setting. Thus, it ensures the study comes up with suggestions that can help to improve the existing situation.

The researcher targeted a population of () in order to achieve the study objectives. Both health service officers and head of household were uninvolved during data collection stage. According to 2002 census, Kasulu district council has (HH/ People).Morgans() formula used to determine the sample out of the total population living in Kasulu District. A multistage sampling procedure used to establish clusters such as households and heads of household were randomly selected from the clusters established. The purpose was to get a representative sample and avoid subjectivity during the study. The researcher used questionnaire instrument of five point Likert scale to collect data from participants. I.e Strongly Agree (SA), Agree (A) and No idea (NA) as well as Disagree (D) and Strongly Disagree (SD). The administered questionnaire used to find facts and gather facts from participants. To ensure appropriateness of the instrument, the researchers conducted a pilot to test both content and face validity. Later, a split half technique used to test the instrument reliability and the result shows that proved that the instrument was reliable. The instrument test indicated a high core of 0.8 correlation of co efficiency. That means it was proved to be consistency and give the same results when administered into different environments. The data generated in the study were organized, coded and analyzed through frequency, mean and percentages. While the analyzed data were presented and interpreted using percentages, figures and charts.

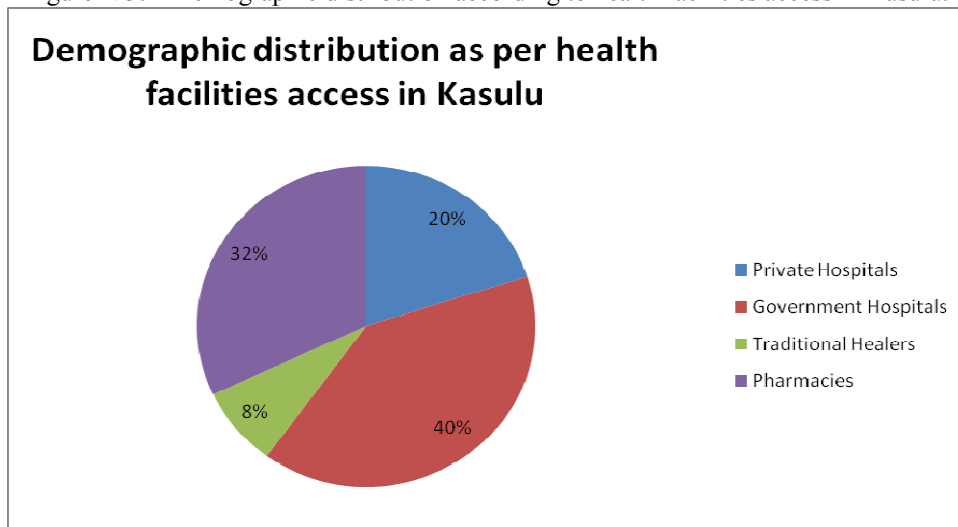
4.0 FINDINGS AND DISCUSSION

This part presents the analysis, interpretation and discussion of the findings. In that case, the analysis was focused on Local Government Reforms Program and its contribution towards health service provision in study area.

4.1 Local Government reforms on quality and capacity to delivery health services in Kasulu

The figure No: 1 below shows how respondents were distributed into various health facilities. The study categorized health service delivery into four groups. That is private hospitals, government hospitals, traditional healers and pharmacies. Either, these categories reveals that, there is a big challenge on providing quality and adequate health facilities in Kasulu. Whereby, the study indicates that still majority of people living in Kasulu have difficulties to access health services. The respondents identifies that, there are various reasons led into poor management of quality health service delivery. Also, the revealed that Kasulu district had a low capacity to offer adequate health services both facility and expertise. Though there is existence of different health boards and committees at village and ward level. But, these boards and committees found to inactive or less participatory. The study noted that even some villagers did not have the knowledge of whether committees were in existence or not. The situation caused poor diagnoses, poor dose administration and increased belief on traditional healers. The study indicates that, only 60 percent people living in Kasulu attending conventional diagnosis and medication. This includes 20 percent and 40 percent of people attending private and Government hospitals.

Figure NO: 1 Demographic distribution according to health facilities access in Kasulu.



Source: Survey data, 2013

Furthermore, the study tried to assess the effectiveness of Local Government Authorities to undertake health service management principles and objectives of Local Government Reforms Program. The district LGRP

secretary informed that health and education sectors were among the sectors which started to operate in Kasulu district. However, the impact of health service committees is low in planning and management of health sector. Despite, the efforts to provide guidance to select the committee members and their responsibility there is little efforts to support the health service committees. For instance; one of the criteria to obtain the committee membership is through vote. Instead in some area members are obtained according to qualifications and expertise. Whereas, some of the villages in Kasulu the health committees members are clinical officers and village officers. This means there is no standard to select health committees' members. This is one of indicators to show there is low level of community participation and transparency.

Meanwhile, villagers were asked that, if they are aware of committees responsibility. The study shows that 51.2 percent of respondents did not know both functions and responsibilities carried out by health committees. Other respondents (48.8 percent) mentioned the functions of the committee are mobilization of the community on family planning, fighting against HIV/ AIDS and provision of training against gender discrimination. Since, there is a low level of committees operation at the village level. It can be recommended that there is poor community involvement in health related issues. Likewise it indicates there is a greater possibility that there is a poor flow of information to the citizens and poor networking with the community at large. This has implication for community not to realize the changes brought about by health committee under LGRP in health related issues. The committees are formed for the purpose of being there and not to work as important organs in the community. The findings are against National Health Policy (1990) where one of its objectives is to create awareness and promotion of community participation in health related activities.

Rather, the researcher was interested to know the availability of MCH services in the study area. The finding shows that MCH services are available in the district and in village specific where this study was conducted. Due to inadequate flow of information from district level to village level, and changes in provision of MCH services, community have not realized changes brought about by LGRP in the area. For instance, in Rusesa and Nyakitonto the MCH services can be accessed through health centers rather than hospital dispensaries and TBAs. However, people access health services depending upon availability of centers; TBAs are found to be easily accessible unlike hospitals and dispensary. There are marked slight differences between the two villages in service sources. In Nyakitonto 59.5 percent access services from health centers while 57.6 percent of Rusesa village access MCH services from health centers. Almost equal percent in each village access MCH services from TBAs. According to population census report 2002, the two villages had a population of 8,172 and 8,271 people for Nyakitonto and Rusesa respectively; where by the required standard for dispensary is to serve a population of between 6,000 and 8,000 people which means that each village requires its dispensary as far as the village population stated above is concerned. Since those dispensaries serve more than two wards each, its capacity to serve all people is limited (URT 1990).

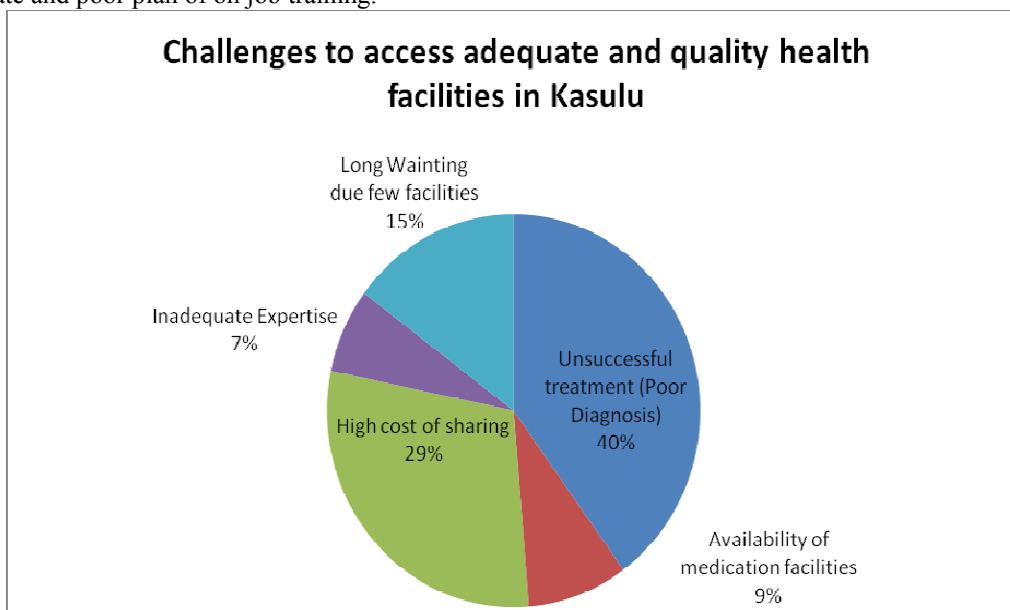
Among the objectives of LGRP was to contribute on improved quality, access and adequate delivery of health services. This study examined the contribution Local Government Reform program on improving health services in Kasulu. The findings indicated that, LGRP contributed to improved health services facilities in dispensaries. For instance this resulted to increased number of children that the district was able to serve as follows: In 1997, 7790 children were served, in 1998, 11157 children, 1999, 12060 and in 2002, 49398 children. Either, from the district health official data, it was also observed that the number of health staffs has been on increase. This increase has been found to be a result of ongoing LGRP at district level. As well, clinical officer of Rusesa dispensary said that basket fund is a result of LGRP that has large contribution on improvement of health status at village level.

On the other hand, the respondents identified that, there is a moderate satisfaction level offered to the community through health services provided by local government system under LGRP. Yet, the government insisting that the national health policy has a scope to upgrade health status. But, the emphasis is on raising life expectancy through improved material and child care services. The health sector reform is closely linked with LGRP, which calls for decentralization of services provision to the local authorities. The decentralization policy aims at improving the quality and quantity of services provided to people that can be realized (MOH, 1994). In this case, yet LGRP has not shown clear effectiveness in health services delivery. Also, because of the good number of interventions in health sector, it is difficult to find out the extent at which LGRP has contributed to the health sector hence reduction of poverty.

4.2 The challenges to offer adequate and quality health facilities services in Kasulu.

There were various challenges facing provision of adequate and quality health services in Kasulu. So far this study revealed that Kasulu has inadequate health service workers. Even the few available workers have inadequate expertise. The shortage of expertise and facilities are causing long waiting queues in health service centers, dispensary and hospitals. Likewise, It was found out that majority of people living in Kasulu depend upon the TBAs to access medical services. The study further investigated the role of TBAs and it was mentioned that the TBAs offer a range medical services including counseling of pregnant women and children. But the biggest challenge is, there are inadequate health service personnel. Meanwhile, the available personnel had

inadequate and poor plan of on job training.



Source: survey data, 2013

Furthermore, the study examined how the national health policy helped to increase the number of staffs and build human capacity. The researcher intended to know if there were trainings attended by TBAs under Local GRP. The research findings revealed that only 10.7 percent of the TBAs had attended trainings. It was difficult to justify that those trainings emanated, out the LGRP or because of other reasons. For instance, nurses and clinical officers recognizes the performance of TBAs in MCH service delivery as at Nyakitonto village there are 4 and at Rusesa there are 5 trained TBAs. Through discussion the researcher was informed that those trainings were the result of LGRP. Also Nyakitonto clinical officer reported that they were expecting to undertake training to TBAs in the coming financial year.

With respect to health staffs, District Medical Officer (DMO) said that there were an increase of staff of different cadres from 302 in 2001 to 388 in 2005 although still they are experiencing shortage of staff, he added MCH service facility was the one where many staff (46 people out of 86) were based in. Also, he said that each dispensary in the district has clinical officers and to build workers capacity building, they used to undergo on the job training for the purpose of increasing their skills (URT, 1990). Either, the community driven model is among the models suggested by government in order to support government efforts towards resources management. It was formulated and implemented by the Tanzania Government with the intention of addressing problems which constrained the performance of the local government authorities such as the human resource capacity and management being weak and this seriously constrained performance by Local Government Authorities, weak leadership and poor management of the councils, shortage of properly qualified, disciplined and committed personnel, shortage of revenue due to narrow tax base, over-employment within the Councils and lack of transparency and accountability in the conduct of Councils' business. LGRP was expected address these problems. This study was designed to find out to what extent LGRP contributed to reducing these problems in health sector in particular. The reason behind is to find out if the reform has brought changes to health service provision. Still, the approach did not do much as far as the councils concern. This was due to inadequate government efforts and political will to support the approach.

4.3 Community involvement in planning and implementation of health related activities at village and ward level.

The study also assessed the level of community involvement in various aspects including participation, contributions and information sharing in meetings. It was revealed that majority planning meetings have partial presentation of community members. Or sometimes there was no community participation in health services meetings at the village and ward level whereby it is contrary to the health sector reforms. The policy states that, community has a responsibility of airing out their ideas for the purpose of improving health status. Since no meetings involved the community, therefore there was no room left for community to participate in health planning committees. The National Health Policy (2003) aims at emphasizing community to participate from planning to implementation stage of health related activities. It can be concluded that LGRP has less or no influence in holding meetings pertaining health related activities.

Rather, the basket fund is a major funding source to undertake health services activities. Whereby, the community participation includes contribution of cash and in-kind. There are various examples of this form

community contribution, for instance people can pay money to support construction works, buying medical facilities. But, in other occasion they contribute their physical energy (labor power). The study shows that there is low level of community awareness towards health services contribution. The results showing that 76.2 percent of people living in Rusesa and Nyakintonto villages believe that it is government has to take full responsibility on offering health services. It's less than 20 percent of people claim the full responsibility of making contributions to support health services operations. Meanwhile, the sector reforms state that community has a responsibility of contributing for the services to ensure sustainability.

Either, the study found that there is insignificant presentation of community on income and expenditure committees. All the two villages, Nyakitondo and Rusesa responded that they have no information related to income and expenditure of health related services. On the other hand it not only community that is not involved on income and expenditure committees, but also the health service workers. For instance the clinical officers reported that even they are not informed about expenditures or approved money located for the dispensaries. Whereas, the dispensaries are required to receive money from the government in order to offer a range of services such as consultancy and medications. This implies that there is a problem of transparency on managing the public funds. The LGRP should put focus on the planning capacity of councils and local communities. Progress is expected to be facilitated by the adoption of the O & OD methodology. Villagers are expected to be at a position of preparing their own plans and be incorporated in the district plans (URT, 2005). The Ministry/ PMORALG need to view provision of quality health service at district and local level as their priority. It includes helping local authorities to better define priorities in the essential health package based on burden of disease; integrating health service delivery and focusing strongly on quality assurance services (HSSP 2003).

5.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY

Since the effectiveness of health service delivery is determined by the organization system of local government and targets to fulfill the objective of LGRP in relation to health services delivery, awareness is important as community indicated to be aware on the implementation of LGRP in their area.

Level of awareness has got an influence on appreciation of changes realized on health services delivery by local government that is at village and district level. In the villages there are village health committees, which are found in large committee known as social service committee. Criteria set for a person to be a member of the committee were by vote from being a member a Village Government and by qualification especially health workers. Although the presence, still community have not realized functions performed by those committees. This indicates that there is poor community involvement in health related issues particularly health services which is contrary to National Health Policy (2003) where one of its objectives is to create awareness and promotion of community participation in health related activities.

In the villages where the research study took place had dispensary in each; however MCH services are obtained from other facilities like TBAs. Due to lack of flow of information from District level to village level, and changes in provision of MCH services, community have not realized changes before and after introduction of LGRP.

Among the objectives of LGRP was to improve quality, access and equitable delivery of health services. There is an improvement on MCH services under LGRP since were; increased health facilities at dispensaries and health workers as reported by clinical officers and DMO. However, the level of satisfaction of community with MCH services provided in local government system under LGRP was moderate. Human capacity has been built in the district where by TBAs have undergone trainings related to MCH services. The objectives of trainings were to equip TBAs with safe delivery procedures and, HIV/AIDS prevention measures during delivery from infected mother to child and, infected mother to TBAs. Other workers attended on the job training under the LGRP; there was an increase of staff of different cadres from 302 in 2001 to 388 in 2005 although they are experiencing shortage of staff.

The level of community involvement is determined through different aspects including participation in meetings, however there were no meetings related to health sector, conducted as it was revealed from the study. The information is contrary to health sector reform, which states that community has responsibility of contributing their ideas for the purpose of improving health status. Basket fund was mentioned as the only source of fund for health related activities. There is no transparency on health related funds to community as no system of being informed on income and expenditure unlike other sectors like education.

5.2 CONCLUSION

Effective, responsive and responsible local governments are important not only for the local communities, but also for the entire nation to enhance democratic and developmental public institutions. Citizen participation and accountability are issues that are now addressed by an increasing number of politicians, professionals, and civil society leaders in Tanzania. The public have become more aware of their rights and responsibilities, but there is a need for more committed political, administrative and civic leaders in order to attain the objectives of the local

government reform programme. Perhaps the most easily overlooked lesson about the local government reform in Tanzania is that devolution takes a long time to achieve. The experiences of Western countries illustrate this well; it took centuries for today's industrialized countries to develop reasonably effective local government authorities. It is therefore not surprising that Tanzania's record to date is yet to meet expectations.

Sustainable change demands sustained effort, commitment and leadership over a long time. Mistakes and setbacks are normal and inevitable components of the process. The big challenge is to use failures as learning opportunities, rather than as excuses for abolishing reforms. Through LGRP, health sector is expected to be improved in terms of service delivery at local level under good financial management system, and human capacity building at all levels from village to national level. To some extent LGRP has contributed in improving health status in Kasulu District through increased health facilities and staffs. However, the reform has contributed nothing as far as community participation in planning and implementation of health activities. Since among the objectives of LGRP, National Health Policy and Health Sector reform, a point of community participation has not been attained, therefore health service delivery is still low as community cannot hold any person accountable for inefficient service delivery.

5.3 RECOMMENDATIONS

Basing on the revealed situation in Kasulu district with specific to MCH services delivery under LGRP, the programme has not achieved its objectives. Therefore, the study recommends the following to district council:

To increase the number of dispensaries in the district especially in those villages where there are no dispensaries. To put into practice a system of community involvement in health related issues, this can be done by having health committees aware on their functions that can be realized by community. To develop a system of providing information to the public on income and expenditure of health related funds in order to fulfill the objective of LGRP. To direct basket funds to dispensaries in villages so as to increase rate of transparency and accountability on the use of those funds. Example as Primary Education Development Programme (PEDP) was doing where community was involved from planning to implementation of their primary education projects.

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