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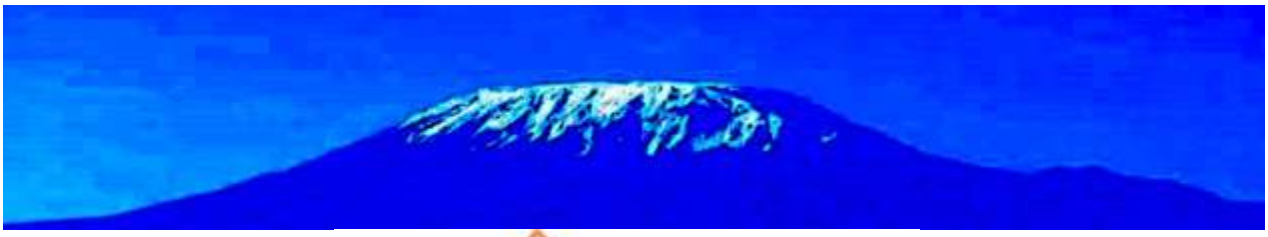

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The Influence of Council Leaders on the use of Health Data in Improving Health Service Delivery in Tanzania

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Abstract

Little is known on the extent to which council political leaders influence the use of health data for improving health service delivery. This paper aimed to examine factors that influence councillors to use health data to improve health service delivery in selected council hospitals. A cross-sectional study design was conducted in six regions that involved twelve wards where council hospitals located. Interview guide was used to obtain information from 12 ward councillors. Thematic manual data analysis was done to extract essential information. The study revealed that only minority of councillors were irregularly invited to participate in the council hospital plans and approval of budget allocation. Some of them occasionally attend quarterly hospital governing committee meetings. Moreover, some of them conducted the promotion of health data use without recommended communication tools. Besides, they hardly requested health statistics from council hospital to assist them with decision making. It is concluded that health service is relative poor because councillors hardly use health data to informed planning and decision making. The study recommends that the Ministry of President Office Regional Administrative and Local Government Authority should restructure the composition of council Hospital Governing Committees to include councillors to deliberate matters of health service delivery issues.

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1.0. Introduction

Political leaders are individuals who are politically active, especially in party politics (Black, 2005). Globally, Political positions range from local government to state governments to international governments (Kappeler and Gaines, 2012). In Tanzania council political leaders, such as councillors, are considered and represent their wards within councils under the Local Government Act. Revised 2000 (URT, 1982).

The influence of council political leaders on health data use is one of the critical components among determinants of health data use that facilitate the improvement of primary health services delivery in health settings (WHO, 2016). Health service delivery is the operational end point of the health care system (World Bank, 2017). It comprises of the provision of a range of services to promote the health of individuals that ultimately lead to positive health outcomes of the population they serve (WHO, 2017). Improvement of health service is an outcome indicator that can be measured in terms of the availability of skilled health workforce, availability of essential health commodities, availability of evidence-based hospital plans and budget allocation (World Bank, 2017).

Improvement of health services delivery greatly depends on adequate use of health data (World Bank., 2015). Because health data use are critical components in the health system for the development of evidence-based plans and interventions that are reflective and responsive to the actual health needs (Nutley and Li, 2018). Health data are useful if they are adequately, accurately, and timely used by decision-makers including political leaders at different levels of health settings (WHO, 2016) However, globally there has been a trend towards increasing inadequate use of health data by politicians for planning and decision-making (Lodenstein et al., 2017). In turn that affected the provision quality of health services (Dianda, 2020; Datta, 2020). Political leaders being active in participating in HFGCs for planning and decision-making can improve health service delivery in health settings (Maluka, 2016). As a result the health system, health outcome, and status of the population they serve are improved (WHO, 2016; World Bank, 2017).

Previous scholars have indicated that the influence of political leaders on health data use can be determined in terms of participation in the health planning process and approval of budget allocation, involvement in data review and interpretations, political accountability on the promoting health data use, and political will to take actions on health data use (Baum et al., 2022; Dianda, 2020; Datta, 2020; Edward et al, 2015). However, health data is inadequately used or not used by political leaders for planning and decision-making, especially at primary health facility levels (Danhoundo, Nasiri and Wiktorowicz, 2018; Joshi and Yu, 2014). Several challenges face politicians to inadequately utilize data include the capacity and experience of the politicians, difficulties in deciding the priorities of the health facilities, personal preferences, and the influence of politics against high demand from the facilities and limited health budget (Dianda, 2020; Okunade, 2005; Lidya et al, 2017).

Some Sub-Saharan countries including Tanzania have adopted decentralization policy for Planning and decision-making in primary health care facilities (Abimbola et al., 2016). The policy focuses on community participation in the management of primary health care through the establishment of health facility governing structures (Abimbola et al., 2016; Anosisye, 2017). Health Facility Governing Committees (HFGCs) is an entity that comprises members who are representative of the community (Maluka, 2016). The roles and responsibilities of members of HFGCs is to manage and monitor health services provision at primary healthcare facilities (Kessy, 2014). However, HFGCs do not include ward councillors as permanent members in those committees (Roman, Cleary and Mcintyre, 2017), although Councilors have the mandate to

approve health plans and budget allocation, promote health data use, be involved in data review stakeholders meetings, and request data from council hospitals for planning and decision-making(Muhanga and Mapoma, 2019).

In Tanzania, local governments were established by the 1997 constitution of the Republic of Tanzania under articles 145 and 146. The local governments are categorized into two authorities by specific local government laws. For instance, urban councils that include City, Municipal, and Town Council are established under Local Government Act No. 8 of 1982. District Council that includes District Councils and Township Authorities are established by Local Government (District Authorities) Act No. 7 of 1982. The governments except village councils are led by councillors that representing their political parties. A councillor is the chairperson of Ward Development Committees (WDC) that comprises the heads of sectors at the ward level. WDC meetings are conducted every quarter to make decisions concerning all sectors including the health sector. The council hospitals have functional Hospital Governing Committees that comprising of other members of community representatives but, ward councillors are not members of those committees. The councillors are invited members of those committees. The meetings of such committees are conducted every quarter for discussing and recommending all matters related to managerial and service delivery issues in council hospitals (Maluka, 2016).

Fowler (1995) asserts that councillors are representatives of the community in particular wards in political perspectives, therefore, the councillors are expected to use health data from health facilities that are allocated within their wards for decision making then provide feedback to the community on the decisions made in the councils hospitals (Kessy, 2014). This activity can be done quarterly through open meetings and Ward Development Committees (WDC). Councillors irrespective of the different political ideologies are responsible for the overall development of the ward including council hospitals within which their wards operate (Max, 1991).

Collectively councillors perform many duties including but not limited to being invited to health facility planning processes and budget approval, being involved in data review and presenting findings through HFGC meetings, health promotion, and political will to take action on health data use (Datta, 2020; Dianda, 2020; Baum et al., 2022, Edward et al., 2015). Other duties include reviewing and implementing policy, strategies, and guidelines for health-related issues, deliberating and deciding on the council`s development and by-laws, supervising the conduct of the council`s administration and management about the implementation of development projects (Lodenstein et al., 2019; Maluka, 2016). However, it is unclear whether councillors influence health data use for the improvement of health services delivery in health facility settings. Therefore, this study aimed to examine to what extent council political leaders influence health data use for the improvement of primary health services delivery in selected council hospitals in Tanzania.

1.1. Theoretical Framework

Theory of change for data use was used to guide the study which was developed from empirical studies and objectives of the study. The theory of change explains how to improve data systems and accelerate data use to perpetuate a cycle of better data production and use of information for the improvement of health service delivery (Arenth et al., 2017). The assumption of the theory states that better data use and regular data use create a culture of data use practices leading to better decisions and improved health service delivery (PATH and Vital Wave, 2016).

This theory comprises of the predictor variables such as political accountability through promoting health data use, hospital plans and approval of budget allocation, involvement in data review and

presenting findings, and political will to take action on data use (PATH and Vital Wave, 2016; Arenth et al., 2017; Baum et al., 2022).

The theory also involves consumable information (health data use) which can be further analysed, comprehended, and employed by decision-makers who take and promote evidence-based actions. The consumable information includes data–informed planning and budget allocation process, data visualization and sharing information to relevant stakeholders, data review, and data-informed advocacy meetings. Simultaneously theory of change involves the outcome variable which is improvement of primary health service delivery as outcome variable.

2.0. Methodology

Study area

The survey was conducted in six regions involved 12 council hospitals namely; Mbalizi Councils Designated Hospital - Mbeya Region, Mjimwema Municipal and Peramiho Council Designated Hospital - Ruvuma Region, Hai and Same District Councils - Kilimanjaro region, Magu and Nyamagana Councils - Mwanza Region, Bunda and Tarime Town Councils - Mara Region. The regions and council hospitals were selected based on Star Rating Assessment conducted Tanzania in 2018 to assess the quality and performance of primary health services delivered at primary health facilities level across the country (MOHCDGEC, 2018).

Study design

A cross-sectional design was conducted in which a qualitative data was collected from study population at a specific point in time. This design was selected because it allows the researchers to collect numerous variables of the study population at once and it provides the current information that researchers want to study.

Sampling techniques and procedures

The study used a multistage sampling technique to select the surveyed regions and councils hospitals. The regions were included based on the majority of council hospitals with high performance on health service delivery (3-star and obove score) and the majority of council hospital with low performance of service delivery (below 3-star score). The regions with the majority of council hospital performed high involved Mbeya, Kilimanjaro and Mwanza while the regions with majority of hospitals with under poor performing category included Songwe, Ruvuma and Mara. Thereafter, the council hospitals were categorized into two groups of high-performing council hospitals (with 3-star plus scores of 60% or above) and low-performing council hospitals (with 3-star plus scores of 59% or below). The criteria of selecting council hospital was based on if it was in the category of either a high-performing or low-performing hospital with regards to Health Facilities Performance Technical Review Meeting (MOHCDGEC, 2018).

Then purposively sampling technique was performed to obtain twelve councils from low performing hospital and from high performing hospitals as documented in Health Facilities Performance Technical Review Meeting (MOHCDGEC, 2018).

Sample size

A convenience sampling method was used to enrol 12 councillors from the wards where council hospitals are located to participate in this study. However, the number respondents were based on saturation point principles.

Pre-test of interviewed questions
Prior to the actual data collection exercise, a reconnaissance survey was conducted to obtain a general picture of the areas. A pilot study was done purposely for testing the reliability and validity of data in order to detect weaknesses in designing interview guide.

This exercise was achieved by distributing the interview questions to 6 councillors, of those, 3 were from Momba District Council in Songwe region and 3 from Bunda District Council in Mara region. The focus of the test was to check the relevance of questions, time used in the interview sessions and ability to retrieve relevant data. After the pre-test, rectification steps identified questions were taken to revise or exclude questions that found to be redundant or vague by the respondents. However, the results of this pre-test were not included in the overall analysis of this study.

Data collection methods
The researchers opted for the qualitative method through In-depth interview method to obtain information from 12 councillors to understand how they influence on health data use for the improvement of health service delivery in council hospitals. The work was done within 24 hours. A team managed to spend one day in each of the 12 councils.

Data collection tool and Procedures
Interview guide checklist was designed in English version and translated into Swahili for interviewing the respondents. During interviews, the researchers used various probes to obtain relevant information from the interviewees. More probing was done when new insights emerged from the principal question. The researchers conducted interviews for at least one an hour for each councillor. A total of 12 councillors were interviewed. Mobile phone through voice recorder was used to interview 12 councillors in 12 wards where council hospitals are allocated .

Data analysis
The study employed qualitative data analysis in which manual thematic analysis was performed to describe main themes and sub-themes that were arising from councillors. Recorded information was transcribed in the same day after the in-depth interviews done. The manual analysis was done by developing a code list from multiple readings of transcripts. This analysis was followed by open coding to identify major themes and sub-themes that emerged from the data which were later related to the study objective. Results obtained from qualitative method were triangulated for interpretation. In a case where quantification of results was needed, data were summarised into percentage.

Ethical considerations
Ethics approval for this research was granted by The National Institute of Medical Research (NIMR) in Tanzania with Ref No. NIMR/HQ/R.8a/Vol.IX/4251. Permission to conduct the study was also obtained from the relevant regions, districts and health facilities and authorities which provided permission to access study participants. A Signed written informed consent was obtained from each participant after explaining the purpose, benefits procedures and risks of the study.

3.0. Results and Discussions

Extent of health data use
In the context of the usage of health data for planning and decision making, the majority of respondents reported that most of time they did not use data were presented by health managers through health governing committees because always they rely on the interest and demand of their voters. For instance one councillor from Chunya District Council emphasized that**;**

we always plan and decide based on the interest of our voters needs because without doing so we will lose the position in the next votes that why most of the time we have been trying to convince health managers to plan projects based on the interest and needs of our voters in respective wards (IDIs Chunya ward councillor).

The influence of political leaders on health data use

The influence of ward councillors on health data use was examined in terms of participating in hospital plans and approval of budget allocation, involved in data review and advocacy meetings through quarterly HFGCs, promotion of health data use and political will to take action on health data use

Participation in hospital plans and approval of the budget

When the researchers asked the councillors whether they were invited to participate in the discussions and approval of council hospital budgets based on existing data systems and other sources of data, only few (n=3/12) of respondents reported that sometimes they have been invited but not all the time. Others were not invited to attend in those HFGC meetings. For instance, one councillor from Magu District Council affirmed,

Sometimes I had been invited to participate in the hospital planning process and approval of the budget but I'm not a member of that committee so I have no decision-making power in those meetings because I`m an invited member (IDI, Isandura Ward Councillor*).*

Further, another councillor from Tarime Town Council said that;

As an invited member it was difficult sometime to decide whether to agree with data presented by Health Managers or agree with our proposed activities from community needs during the discussion of hospital plans and budget allocation. Ultimately we agreed upon when Health Managers provide concrete evidence based on their data for a particular planned activity (IDI, Bomani Ward Councillor).

Involvement in data review and interpretation of findings

When the researchers asked the councillors whether they were invited to attend quarterly HGCs meetings, minority of councillors reported having sometimes been invited to attend the meetings, and other majority reported that they were not invited to those meetings. When the researchers asked councillors why they were not attending the meetings regularly, they said, that because they were not members of HGCs although they have a mandate over council health staff. For instance, one councillor from Songea Municipal Council said,

one day I was discussing with the Medical Officer In-charge telling him that I'm a very important person who has convincing power to the community, therefore invite me to every meeting because it will create a common understanding to address and solve problems of our hospital. (IDI, Mjimwema Ward Councillor).

The researchers were interested in knowing whether the reports were presented by Medical Officers In-charge were adequately informed by data through dashboards and whether the health data use component was permanently incorporated in the agenda of those meetings for discussion, decision making and recommendations. Majority of councillors reported that they have never seen the health managers presenting data through PowerPoint presentations. However they reported having always been discussing reports through prepared files with inadequate analysed and interpreted data. One councillor from Hai District Council said,

"Most of the time we are discussing managerial issues such as hospital staff disciplinary issues and employment of hospital staff through files but we are not discussing findings of specific programs performance indicators which could be presented by Hospital Managers" (IDI, Boma la Ng`ombe Ward Councillor).

Furthermore, when councillors were asked whether they had ever used a simple communication tools such as scorecards during presentation of finding through HGC meetings, almost all interviewed councillors reported having never seen Health Managers presenting findings on performance indicators in terms of scorecards through those meetings. One councillor from Same District Council insisted "*we prefer presentations that having pictures and tables with different colours indicating the trends of performance indicators because they help us to understand what is presented instead of using complicated graphs and charts"*(IDI, Kisima Ward Councillor*).*

Political accountability on promoting health data use

The researchers were interested in knowing if councillors were conducting health data use promotion in their respective wards and whether they were using specific tools which were designed by health staff for use by councillors*.* The majority of councillors reported having always been conducting health promotion on health-related issues in collaboration with health care providers. However, the promotions were done only during outbreak of diseases and specific campaigns for promoting immunization campaigns, and outbreak of diseases such as cholera, diarrhoea and COVID-19 through open ward meetings and sensitization meetings but not routine. For example one councillor from Magu District Council emphasized

> "*I'm actively conducting health promotion through sensitization meetings, sometimes I do that even in any event occurring in the community such as burial ceremonies and house-to-house visits"* (IDI, Isandura Ward Councillor*).*

When the respondents were asked by the researchers which communication tools they were using for health data use promotion, they reported not having any specifically designed communication tools; but they always used leaflets, speakers, posters, and reports prepared by health workers for promotion*.*

Furthermore, when the respondents were asked whether those tools were appropriate for the community with different people in terms of the level of education, they reported not being sure whether the audiences understood what had been promoted to them, but it would have been better to use simple communication tools such as pictures, and colours which would be easily understood by all people who attend the health promotion meetings.

The political will to take action on health data use

Councillors were asked whether they were requesting health data from council hospitals that located in their wards and using them for decision-making, Minority (n=3/12) of the respondents reported they were not regularly requesting health statistics from those hospitals. However, they were requesting those statistics during the outbreak of diseases such as COVID-19 and Cholera. One councillor from Mbozi District Council in Vwawa Ward said;

> *We know that Mbozi Council Hospital is situated in our ward but I think it was our weakness, therefore this interview has opened our eyes that we are supposed to request health statistics from that hospital for discussion and decision making through WDCs and other council committees quarterly (*IDI Vwawa Ward`s Councillor*).*

Discussion

Generally, there was inadequate use of health data by council political leaders to inform decision-making in primary health facilities in Tanzania. The study results are consistent with a study done elsewhere Dianda (2020) who asserts that the majority of politicians hardly use health data during the planning process. The politicians, among other things, are subjected to low capacity, inadequate experience, difficulties in deciding the priorities of the health facilities, personal

preferences and community needs, and the influence of politics. A similar study done Datta (2020) indicates that politicians' participation in the hospital planning process and approval of budget allocation seemed to be a challenge in various primary health facilities in developing countries. These are in line with our study findings which indicate that the majority of councillors were inadequately participating in hospital plans and approval of the council hospitals because councillors are not members of HGCs. However, a similar study done elsewhere by Joshi and Yu (2014) reveals that the active participation of political leaders in the hospital planning process and approval of budget allocation was a determinant of health data used for government health spending. Another study elsewhere done by Lydia et al (2017) indicates that there was adequate political leaders` participation in approval of budget allocation that represented the vulnerable and minorities citizens as a results there was a significant rise in government spending on health. Likewise, a study done by Dianda and Sirpé (2020) indicates that the active participation of political leaders in health governing committees had a positive effect on the improvement of health service delivery in some of primary health facilities.

Regarding the involvement of political leaders in health facility governing committees, previous scholars have indicated that the engagement of Health Managers and representatives of the communities such as council political leaders in health facility governing committees was a significant factor in improving health performance programs (Kinyenje et al., 2022). This is contrary to the results of the current study which indicates that HFGCs meetings were normally conducted but councillors were inadequately and irregularly invited to attend those meetings because they are not members of HGCs which significantly affected the influence of health data use in health settings. The study conducted by Jensen (2019) reveals that political leaders are elected leaders who represent the community and have stronger countervailing power as elections may enable health governing committee representatives to claim to be representing the entire community.

Furthermore, the current study findings reveal that there was no designed simple communication tool such as a scorecard that was used by Health Managers for presenting findings through quarterly HGC meetings which brought difficulties to political leaders in understanding the findings were presented. This is contrary to the study done by Edward *et al* (2011) who found that health facility governing committees were using a scorecard as a successful way of monitoring performance indicators and improved health service delivery. Two similar studies from Afghanistan and one study from Kenya carried out by Nutley, McNabb. and Salentine (2013) and Edward et al (2015) provide evidence that scorecards through data visualization were used effectively as a performance management tool when combined with the participation of Health Managers and policymakers through health facility governing committee meetings respectively.

In the context of promoting health data use, the study findings indicate that always political leaders were used for promoting health-related programs with different communication tools such as leaflets, posters, health reports, and speakers, especially during campaigns and outbreaks of diseases. However, they did not have specific simple tools such as scorecards for promoting health data use which made it difficult to use present findings to audiences at the community level. Contrary to a study elsewhere Danhoundo, Nasiri and Wiktorowicz (2018) found that using scorecards was a successful social accountability intervention through health promotion by engaging political leaders and health facility managers; ensured the availability of simple communication health promotion. integrating data and information collection in scorecards which fostered trust and mutual understanding between citizens and leaders. A similar study, which was carried out in Malawi by Gullo, Galavotti and Altman (2016) found that the Community Scorecard (CSC) contributed to the availability of health services, access, utilization, and quality of services delivery in health settings. Another study done elsewhere Edward *et al* (2011) found that the

CSC seemed to be useful in building trust and strengthening relationships between the citizens and service providers and improved the user-centred dimension of the quality of services.

Regarding political will to take action on health data use seemed to be a challenge facing politicians in developing countries, especially at primary health facility levels (Baum *et al.*, 2022). These concur with the current study results which indicate that almost all councillors reported that they were not requesting health statistics from the council hospitals for discussion and decision-making through quarterly Ward Committee meetings which significantly affected the use of health data for decision making. These study findings supported by the study done by Chancel (2018) who found that various governments in Sub-Saharan countries have had limited success in translating well-intended political will into action on health data use issues. Conversely, the report from Mid Term Review HSSP IV (2015-2020) indicated that health data use was supported by the highest authorities in the Tanzania government including politicians for requesting data through scorecards, and data were often produced quarterly for decision-making (MOHCDGEC, 2019).

Limitations

The researchers used only audio-recorder through mobile phone method of interview to obtain information from respondents without accessing the respondents face-to-face. The study interviewed only ward councillors whose council hospitals were located in the respective wards to provide relevant information on the influence of data used for health service delivery improvement.

4.0. Conclusions and Recommendations

It is concluded that improvement of health service delivery in council hospitals is relatively poor due to inadequate use of health data by councillors for planning and decision-making in primary health facility settings. These significantly affected by inadequate participation of political leaders in hospital plans and approval of budget allocation, irregular involvement in data review and data-informed advocacy meetings, irregular promoting health data use, and political will to take action on data use in health settings. It is recommended that the PO-RALG should restructure the composition of members of HGCs to include ward councillors as permanent members of those committees to deliberate matters of managerial and services delivered in health settings. The management of council hospitals should advocate for the council political leaders to adopt informed evidence-based plans and findings presented by health managers using simple communication tools such as scorecards through quarterly HFGC data-informed advocacy meetings.

Implications of the study

Body of knowledge

Study findings have widened the insights and understanding about the influence of council political leaders on health data use for improvement of health service delivery in health facility settings. It also serves as benchmark to conduct further research on this area.

Implication for practices

Study findings will be used as a guiding tool and help other council hospitals effectively involve ward councils in hospital governing committees. As a result councillors will adopt evidence- based plans and decisions that reflect to actual health needs in health facility settings.

Implications for the public

Council political leaders being active in participation in hospital plans and approval of budget allocation, involvement in data review meetings and data-informed advocacy, promoting health

data use and having the political will to act on health data use will contribute to improving provision quality of health services in health settings, ultimately health outcomes and the status of the population will be improved.

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Competing interests
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Policy Brief

Some middle and low-income countries have adopted decentralization policy for planning and decision-making through regulatory boards and committees. The main goal is to improve quality of governance, service delivery and accountability by decision makers.

In line with the Local Government Act No. 8 of 1982, the Tanzanian government aims at increasing participation of people in planning and decision making as well as creating accountable local governments.

In the context of health sector, the policy focuses on community participation in the management of primary health care through the establishment of health facility governing structures. Health Facility Governing Committees (HFGCs) are entities composed of members who are representative of the community. Even though, Ward councillors are only invitees in such health facility governing committees. As such, they lack influence in such committee. In so doing, the voices of the citizens are undermined in HFGCs. The roles and responsibilities of members of HFGCs is to manage and monitor health services provision at primary healthcare facilities.

Lessons learned

The followings are lessons learned from the study

- Participation of council political leaders in hospital plans and budget allocation is important. Their participation can influence the use of informed data for planning and decision making, ultimately leading to improved health service delivery in primary health facilities.
- Involvement of council political leaders in data review and data informed advocacy meetings through health facility governing committees provide a room for politicians to adopt evidence based plans
- Political accountability through promoting health data use using a simple communication tool such as score cards increase mutual understandings and awareness of health problems in the community and prevent them accordingly.

Policy and Practices recommendations

- Health facility plans and decisions made by health managers, policy makers and politicians should be evidence-based and should reflect the actual needs in the health sector.
- Decision makers, including health managers, policy makers and political leaders, should request reports that are evidence based (informed adequate data) from health facilities for planning and decision making at different levels
- Data –informed advocacy meetings should be regularly conducted to capacitate political leaders on adopting evidence based plans

FURSA ZA USHAWISHI WA MADIWANI WA HALMASHAURI KUTUMIA TAKWIMU ZA AFYA KWA AJILI YA KUBORSHA HUDUMA ZA AFYA KATIKA HOSPITALI ZA HALMASHAURI- TANZANIA

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Ikisiri

Licha ya madiwani wa Halmashauri kuwa viongozi wa kisiasa na wenye fursa za kutumia takwimu za afya kwa ajili ya kuboresha utoaji wa huduma za afya; kwa sasa, kuna kiwango kidogo cha taarifa zinazoonesha ni kwa namna gani viongozi hao wanashiriki kikamilifu kutumia takwimu kwa ajili ya kupanga mipango na kufanya maamuzi kutokana na takwimu zilizopo kwa ajili ya uboreshaji wa huduma za afya katika vituo vya kutolea huduma za afya. Utafiti huu ulilenga kudodosa madiwani wa Halmashauri 12 kutoka kata ambazo hospital za Halmashauri zilipo kwa kutafiti sababu zinazowafanya viongozi wa kisiasa kutotumia takwimu kwa ajii ya kuboresha utoaji wa huduma za afya katika hospitali za halmashauri nchini Tanzania.

Watafiti walitumia njia ya simu za viganjani za vinasa sauti kuwapigia watafitiwa kwa ajili ya kukusanya takwimu kutoka katika dodoso zilizoandaliwa. Utafiti huu ulifanyika katika mikoa sita iliyojumuisha hospitali kumi na mbili za Halmashauri katika mikoa hiyo. Matokeo ya uchambuzi wa takwimu yalionesha kuwa washiriki wachache (3/12) walikuwa wanaarikwa kushiriki mara chache katika vikao vya kamati za usimamizi za hospitali za Halmashauri kwa ajili ya kujadili mipango na kupitisha bajeti za hospitali hizo. Pia, takribani madiwani wachache 3/12walisema kuwa walikuwa wanaarikwa kuhudhuria mara chache kwenye vikao vya kila robo mwaka vya kamati za usimamizi za hospitali kwa ajili ya kujadili na kufanya maamuzi kutokana na taarifa zilizowasilishwa na wataalam wa afya. Sababu za wao kuhudhuria mara chachechache ni kwamba wao ni wajumbe waalikwa na siyo wajumbe kamili wa kamati hizo. Matokeo mengine yalionesha kuwa takribani madiwani wengi (83.3%) walieleza kuwa mara chache walikuwa wanafanya uhamasishaji wa matumzi ya takwimu za afya kwa kushirikiana na watalamu wa afya katika maeneo yao lakini walidai daima hawana nyenzo zenye tafsiri rahisi zilizooandaliwa na watalamu hao kwa ajili ya uhamsishaji kwa kupitia mikutano mbalimabali ikiwemo mikutano ya hadhara katika maeneo yao.

Aidha, matokeo yalionesha kuwa madiwani walikuwa hawaagizi takwimu za afya kutoka katika hospitali za halmashauri zilizopo katika maeneo ya kata zao kwa ajili ya kuzijadili na kutoa maamuzi kupitia vikao vya robo mwaka vya kamati ya maendeleo ya kata. Utafiti huo unahitimisha kuwa madiwani walikuwa wanatumia takwimu zilizoandaliwa kwa kiwango kidogo sana na watumishi wa afya kwa ajili ya kupanga mipango, kupitisha bejeti na kufanya maamuzi kupitia vikao vya kamati za usimamizi huduma za afya za hospitali za Halmashauri kwa sababu ni wajumbe waalikwa na siyo wajumbe kamili wa kamati hizo. Pia Inashauriwa Madiwani kuwezeshwa kuagiza takwimu kutoka hospitali, kupanga mipango na kupitisha bajeti kutokana na takwimu zilizopo. Hii itasaidia kuimarika kwa ubora wa huduma katika vituo vya kutolea huduma za afya nchini. Aidha, Inashauriwa kuwa TAMISEMI Kama wizara yenye mamlaka kufanya marekebisho ya muundo wa wajumbe wa kamati za usimamizi za hospitali ufanyike kwa kuwajumuisha madiwani wa kata ambapo kila hospitali ya Halmashauri ilipo kuwa wajumbe kamili wa kamati hizo kutokana na majukumu yao ya kazi waliyonayo kwa ajili ya kuboresha huduma za afya katika vituo hivyo.