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RESEARCH REPORT ON

AN ASSESSMENT ON EFFECTIVE MEDICAL RECORDS MANAGEMENT FOR IMPROVING SERVICE DELIVERY IN PUBLIC HOSPITALS: A CASE STUDY OF BAGAMOYO DISTRICT HOSPITAL.

BY:

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A Research Report to be submitted to the School of Library, Archives and Documentation Studies (SLADS) as Partial Fulfillment for the Award of Diploma in Records and Archives Management.

August, 2026

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends this report for acceptance by the School of Library, Archives and Documentation Studies. Research report entitled " An assessment on effective Medical Records Management for Improving Service delivery in public hospitals": A case study of Bagamoyo District Hospital, in partial/ fulfillment of the requirements for the award of Ordinary Diploma in Records and Archives Management.

Signature

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Mr.....

(Supervisor)

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I, **Agustino J Mkono,** declare that this report is my own original work and that it has not been presented and will not be presented at any other Ordinary Diploma for a similar or any other diploma award.

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Thank you all.

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DEDICATION

This piece of work is dedicated to my beloved parents for their endless love, sacrifices, and support throughout my studies. It is also dedicated to my brothers and sisters for their encouragement and companionship. May this achievement reflect our shared commitment to hard work and success.

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LIST OF ABBREVIATIONS AND ACRONYMS

AMRO	Assistant Medical Records Officer
BDH	Bagamoyo District Hospital
EHMS	Electronic Health Management System
EHR	Electronic Health Record
EMR	Electronic Medical Records
ERMS	Electronic Record Management System
GoTHOMIS	Government of Tanzania Hospital Management Information System
ICT	Information and Communication Technology
IRMT	International Records Management Trust
ISO	International Organization for Standardization
MOI	Muhimbili Orthopaedic Institute
MoH	Ministry of Health
MRO	Medical Records Officer
NARA	National Archives and Records Administration
SLADS	School of Library, Archives and Documentation Studies
WHO	World Health Organization

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ABSTRACT

This study assessed the effectiveness of medical records management in improving healthcare service delivery at Bagamoyo District Hospital (BDH), Coast Region, Tanzania. It was guided by three objectives: to examine current medical records management practices at BDH, to assess the existing infrastructure for managing patient records, and to identify the challenges affecting records management at the hospital. The study was prompted by the fact that, although BDH registers patients electronically through the Government of Tanzania Hospital Management Information System (GoTHOMIS), clinical information is still recorded in a separate paper file, and when such a file cannot be traced, a new one is often opened instead, so that a patient's earlier medical history is not always carried forward. A descriptive research type and a cross-sectional design were adopted, combining questionnaires and an interview. A sample of 25 respondents was drawn from a target population of 46 staff, comprising 8 doctors, 10 nurses, 3 ward clerks, 3 patient administration staff, and 1 Medical Records Officer, selected through probability and purposive sampling. All 25 questionnaires were returned, giving a 100 percent response rate. Findings showed that BDH operates a hybrid records system, with electronic registration through GoTHOMIS alongside manual paper files, coordinated mainly by the Medical Records Officer. A new file is opened whenever an old one cannot be traced, a practice reported by 72 percent of respondents, mainly resulting in loss of patient history, duplication of records, and delays in service. Although all respondents confirmed the availability of an Electronic Medical Records system, its use remains limited mainly to registration, while filing, storage, and retrieval are still done manually. The main challenges were limited use of the electronic system, poor filing and retrieval, and a shortage of trained records staff. The study concludes that records management at BDH is only partially effective in supporting service delivery, and recommends that hospital management expand electronic system use beyond registration, recruit and train additional records staff, and set clear procedures for tracing files before new ones are opened.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

1.0 Introduction

This chapter presents the background of the research problem, statement of the problem, research objectives (General and specific objectives), research questions, significances of the study, scope of the study, limitations of the study, and operations of key terms.

1. 1 Background of the Study

All over the world, medical records have historically played a central role in the functioning of hospitals and healthcare systems by documenting patient information such as medical history, diagnosis, treatment, and outcomes. Globally, the systematic use of medical records evolved alongside the development of modern hospitals, where documentation became essential for ensuring continuity of care, clinical decision-making, and patient safety (WHO, 2021). Over time, medical records expanded beyond clinical use to support hospital administration, health planning, quality assurance, research, and public health monitoring (Dunlay et al., 2008). The International Records Management Trust (IRMT, 1999) emphasizes that good medical care relies not only on skilled health professionals and adequate facilities but also on accurate, complete, and accessible medical records. Poor recordkeeping has been associated with misdiagnosis, inappropriate treatment, and inefficiencies in service delivery. Consequently, records management principles such as proper creation, maintenance, storage, retrieval, protection, and disposal became integrated into healthcare systems worldwide. In recent years, global health systems have increasingly transitioned from paper-based records to electronic health records (EHRs) to improve efficiency, accessibility, and data accuracy. WHO, 2020 and Afolabi et al., 2019 explained that even with technological advancements, challenges such as incomplete documentation, poor data quality, and weak records management practices persist, particularly in low- and middle-income countries. These challenges highlight that technology alone cannot resolve records management problems without strong institutional frameworks and skilled personnel.

The development of medical records in Africa is closely linked to the introduction of modern healthcare systems during the colonial period, where hospitals relied primarily on manual, paper-based records. After independence, many African countries expanded public

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healthcare services, increasing the volume and complexity of medical records managed within public hospitals (Katuu, 2016). Despite this expansion, poor medical records management has remained a persistent challenge across the continent. Studies conducted in several African countries indicate that medical records are often incomplete, poorly filed, difficult to retrieve, or lost altogether, negatively affecting patient care and hospital performance (Marutha, 2016; Katuu, 2015). Research from Uganda, Ghana, Ethiopia, and South Africa documents problems such as missing pages, duplicated patient numbers, illegible handwriting, and inadequate storage facilities, all of which undermine effective service delivery (Marutha, 2016). Recent literature (2015–2025) continues to show that poor records management contributes to weak monitoring, supervision, and decision-making in public health systems across Africa (Afolabi et al., 2019; WHO, 2020). Although some countries have introduced electronic or hybrid systems, implementation remains uneven due to infrastructural limitations, shortage of trained records personnel, and limited financial resources (Katuu, 2016; Marutha & Ngoepe, 2018). As a result, many public hospitals still depend heavily on manual medical records systems.

Furthermore, in East Africa, similar historical patterns are evident, with countries like Kenya, Uganda, and Tanzania grappling with the transition from colonial-era manual systems to more modern approaches. The region's public hospitals, serving large populations with diverse healthcare needs, have faced compounded challenges from population growth and disease prevalence, leading to increased data volumes that strain existing records management practices (Kilonzo et al., 2023). In Tanzania specifically, public hospitals such as Bagamoyo District Hospital have historically relied on paper-based records, mirroring broader African trends, but with growing emphasis on digital transitions to address inefficiencies like file loss and retrieval delays (TNHREC, 2019). Despite global and regional advancements, many district hospitals in Tanzania continue to experience systemic weaknesses, including incomplete documentation and inadequate storage, which compromise patient care and service delivery (Kilonzo et al., 2023). This assessment on the management of medical records for services delivery in public hospitals, using Bagamoyo District Hospital as a case study, seeks to evaluate these practices in the context of Tanzania's evolving healthcare landscape, highlighting the need for improved systems to enhance quality and equity in healthcare provision.

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1.2 Statement of the problem

Three well-known frameworks explain how patient medical records should be managed. ISO 15489-1:2016 says that every record must be complete, correct, unchanged, and easy to use, so that it can be trusted as proof of the care a patient received. The International Records Management Trust (IRMT, 1999) adds that a hospital should keep a patient's records together under one responsible office, in the order they were made, and easy to find for as long as they are still in active use. The National Archives and Records Administration (NARA, 2018) says that institutions must protect records from being lost and must be able to produce them quickly whenever a decision depends on them. Put together, these three frameworks point to the same expectation: a patient's file should be one complete, unbroken record that can be found instantly whenever it is needed.

At Bagamoyo District Hospital, the way records are handled, as already described in Section 1.1, falls short of this expectation. Government of Tanzania Hospital Management Information System (GoTHOMIS) records a patient's details and gives them an identification number at registration, but everything that follows, diagnosis, treatment, laboratory results, and follow-up notes, is written in a separate paper file that the electronic system does not follow. When such a file cannot be found, the usual response is to open a new one instead of continuing to search for the old one, so the patient's earlier medical history is not always carried forward. Whether these practices, the infrastructure behind them, and the day-to-day problems records staff face while doing this work are good enough to support reliable service delivery at Bagamoyo District Hospital had not been formally checked before this study.

What can happen when such questions are left unchecked is shown, though not proven to apply at Bagamoyo District Hospital, by a case elsewhere in Tanzania's health system. In November 2007 at the Muhimbili Orthopaedic Institute, confusion caused by poor records handling led to two patients, Emanuel Didas and Emanuel Mgaya, being operated on for the wrong condition. Didas had surgery on his head when the operation he needed was on his leg, leaving him permanently disabled, while Mgaya had leg surgery instead of the brain surgery he needed, and later died. The High Court of Tanzania, in Civil Case No. 129 of 2012, found the institute at fault (The Citizen, 2007; WHO, 2017). This example is used only to show, from within the same national health system, how serious the results of poor records management can be; it does not mean that anything like this has happened at

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Bagamoyo District Hospital. The more likely concern at a hospital such as Bagamoyo District Hospital is the smaller, everyday version of the same risk: repeated tests, delayed treatment, and decisions made without a patient's full history. It is against this background that the present study looked at how effective medical records management practices, the infrastructure behind them, and the challenges affecting them are in improving healthcare service delivery at Bagamoyo District Hospital.

1.3 Objectives of the Study

1.3.1 Main objective.

The main objective of this study was to assess the effectiveness of medical records management in improving healthcare service delivery at Bagamoyo District Hospital (BDH).

1.3.2 Specific objectives.

The specific objectives of the study were to:

i. To examine the current medical records management practices at Bagamoyo District Hospital (BDH).

ii. To assess the existing infrastructure for the managing patient medical records at Bagamoyo District Hospital (BDH).

iii. To identify the challenges affecting medical records management in managing medical records at Bagamoyo District Hospital (BDH).

1. 4 Research Questions

The study was guided by the following research questions:

i. What are the current medical records management practices at Bagamoyo District Hospital?

ii. What infrastructure is in place for the management of medical records at Bagamoyo District Hospital?

iii. What challenges do records staffs encounter in facilitating the process of managing medical records at Bagamoyo District Hospital?

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1.5 Significance of the Study

The findings of this study are expected to be significant to Bagamoyo District Hospital by providing information on the current status of patient medical records management. The information obtained from the study may assist hospital management and healthcare workers in identifying areas that require improvement in medical records management practices, available infrastructure, and strategies for improving healthcare service delivery. The study findings are also expected to be useful to students and future researchers at the School of Library, Archives and Documentation Studies (SLADS) by providing reference information for further studies related to medical records management and healthcare service delivery. Furthermore, the study is expected to assist the researcher in gaining practical research experience and fulfilling part of the requirements for the award of an Ordinary Diploma in Records and Archives Management.

1.6 Scope of the study

This study was conducted at Bagamoyo District Hospital in Bagamoyo District, Tanzania. The study focused on assessing the effectiveness of patient medical records management in improving service delivery. It specifically examined medical records management practices, existing infrastructure for managing medical records, and challenges affecting the effective management of patient medical records. The study involved healthcare workers who are directly involved in the management and use of patient medical records, including Medical Records Officers, doctors, nurses, ward clerks, and patient administration officers. The study was limited to patient medical records and did not cover other hospital records such as financial, human resource, procurement, and administrative records. The findings were limited to Bagamoyo District Hospital and may not fully represent other public hospitals.

1.7 Limitations of the study

This study faced a few limitations during the data collection process. One of the limitations was the limited time available to conduct the study, as all research activities had to be completed within the allocated period. The researcher also encountered challenges in meeting some respondents because of their busy work schedules, making it necessary to arrange appointments before administering questionnaires and conducting interviews. Another limitation was that the study was conducted only at Bagamoyo District Hospital. Therefore, the findings of this study may not be generalised to all public hospitals in Tanzania, since medical records management practices, available resources, and working

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environments may differ from one hospital to another. Despite these limitations, the researcher planned the data collection activities carefully and managed to collect all the required information for the study. A further limitation is that the study did not collect data directly from patients or measure patient-level outcomes such as waiting times, diagnostic accuracy, or satisfaction. The effectiveness of medical records management for service delivery was therefore judged indirectly, through what hospital staff reported about practices, infrastructure, and challenges. Any conclusions about service delivery in this report are based on these staff reports, not checked separately against patient data.

1.8 Operation of key terms

1.8.1 Medical Record

A medical record is a comprehensive documentation of a patient's health history, including personal information, diagnoses, treatments, medications, and clinical notes, maintained to support continuity of care, clinical decision-making, and legal compliance (Marutha, 2017).In this study, the term is applied specifically to the physical patient file and its corresponding electronic entry maintained at Bagamoyo District Hospital, with particular attention to the extent to which these two components remain complete, linked, and traceable throughout a patient's course of treatment.

1.8.2 Hospital

A hospital is a healthcare facility that provides medical, surgical, and emergency care services to patients, often equipped with specialized staff, equipment, and infrastructure to diagnose, treat, and manage illnesses or injuries (WHO, 2020).In this study, the term refers specifically to Bagamoyo District Hospital, the public district-level facility that constituted the study area, and to the categories of staff situated within it, namely doctors, nurses, ward clerks, patient administration staff, and the Medical Records Officer, whose handling of patient records formed the subject of the investigation.

1.8.3 Medical Records Management

Medical records management is defined by Marutha (2017) as the systematic process of creating, maintaining, storing, retrieving, and disposing of patient health information to ensure accuracy, accessibility, and compliance with legal and ethical standards.Within the context of this study, the term is applied to the specific practices observed at BDH, namely

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the hybrid creation of records through GoTHOMIS and paper files, the responsibility held by the Medical Records Officer, and the procedure followed whenever an existing patient file cannot be traced, since these were the practices examined under the first objective of the study.

1.8.4 Service Delivery

Afolabi et al. (2019) define service delivery as the provision of healthcare services, including diagnosis, treatment, and follow-up care, in a timely and efficient manner to meet patient needs.For purposes of this study, service delivery is understood mainly through the lens of continuity of care, that is, the extent to which a patient's earlier medical history remains available and usable by health workers, since this was the specific aspect of service delivery that the study questionnaire and interview were designed to capture, as clarified further in the conceptual framework in Chapter Two.

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents the review of related literature relevant to the study on effective medical records management and service delivery in public hospitals. It is organised into four main sections. The first section presents the theoretical framework, which explains the theory guiding the study. The second section reviews the empirical literature, highlighting findings from previous studies related to the research topic. The third section presents the research gap, identifying areas that have not been adequately addressed by earlier studies and justifying the need for the current study. Finally, the chapter presents the conceptual framework, which illustrates the relationship between the independent and dependent variables of the study.

A literature review is an important part of any research study because it helps the researcher understand what other scholars have already found out about the topic. Leedy and Ormrod (2021) explain that reviewing literature helps a researcher describe theoretical viewpoints and look closely at findings from earlier studies. In the same way, Rubin and Babbie (2017) argue that going through literature in a systematic way lowers the chance of choosing a research question that is not relevant. Through this process, a researcher is able to see what gaps still need further investigation, which helps the study add something meaningful to existing knowledge.

2.1 Concepts of key terms

2.1.1 Medical records management

Marutha (2017) defines it as the systematic process of creating, maintaining, storing, retrieving, and disposing of patient health information in order to ensure accuracy, accessibility, and compliance with legal and ethical standards. In a closely related sense, Ngulube and Tafor (2006) describe records management more broadly as the practice of controlling records from the point of creation to the point of disposal, with the underlying goal of keeping records secure while ensuring that they remain available in the right format, to the right people, at the right time. Within a hospital setting specifically, the International Records Management Trust (IRMT, 1999) explains that good record keeping is not a peripheral administrative task but a function that is directly tied to the quality of medical

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care a patient receives, since accurate, complete, and easily retrievable records enable health workers to make sound clinical decisions, while poor or missing records increase the risk of misdiagnosis and inappropriate treatment. Medical records management therefore extends beyond simple storage of paperwork; it is a continuous process touching every stage of a patient's interaction with a health facility. It is within this understanding that the specific types of records generated in a hospital setting are discussed below.

2.1.1.1 Types of Medical Records Found in Hospitals.

a) **Patient case notes**: records created whenever a patient comes into contact with medical staff, containing patient history, diagnostic test results, treatment charts, and records of operations (IRMT, 1999).

b) **X-rays**: large-format photographic or digital records produced for diagnostic purposes at a clinician's request, filed separately due to their size but cross-referenced to the patient's case note file (IRMT, 1999).

c) **Pathological specimens and preparations**: physical samples such as blood, tissue, or bodily fluids taken from patients for laboratory examination and diagnosis (IRMT, 1999).

d) **Patient indexes and registers:** finding aids, kept in card or electronic form, containing patients' names and details used to locate their case notes and related records (IRMT, 1999).

e) **Pharmacy and drug records**: records of drug prescription, ordering, dispensing, and administration to patients (IRMT, 1999).

f) **Nursing and ward records**: records generated within hospital wards, including admission registers, property books, and nursing care notes (IRMT, 1999).

2.1.2 Hybrid Medical Records Management System

A hybrid records management system refers to a records-keeping arrangement in which both electronic and paper-based methods are used concurrently to create, store, and manage records, rather than relying on either format alone (Katuu, 2016). Marutha and Ngoepe (2018) explain that many African public hospitals continue to operate hybrid systems because full electronic transition is constrained by infrastructural and resource limitations, meaning that patient information is often captured electronically at one stage, such as

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registration, while the rest of the clinical documentation continues to be recorded and stored manually.

2.1.3 Service Delivery in Healthcare

Afolabi et al. (2019) define service delivery as the provision of healthcare services, including diagnosis, treatment, and follow-up care, in a timely and efficient manner to meet patient needs. Effective service delivery therefore depends not only on the availability of skilled health workers and adequate facilities, but also on the timely availability of accurate patient information, which links service delivery directly to the quality of a hospital's medical records management practices (IRMT, 1999).

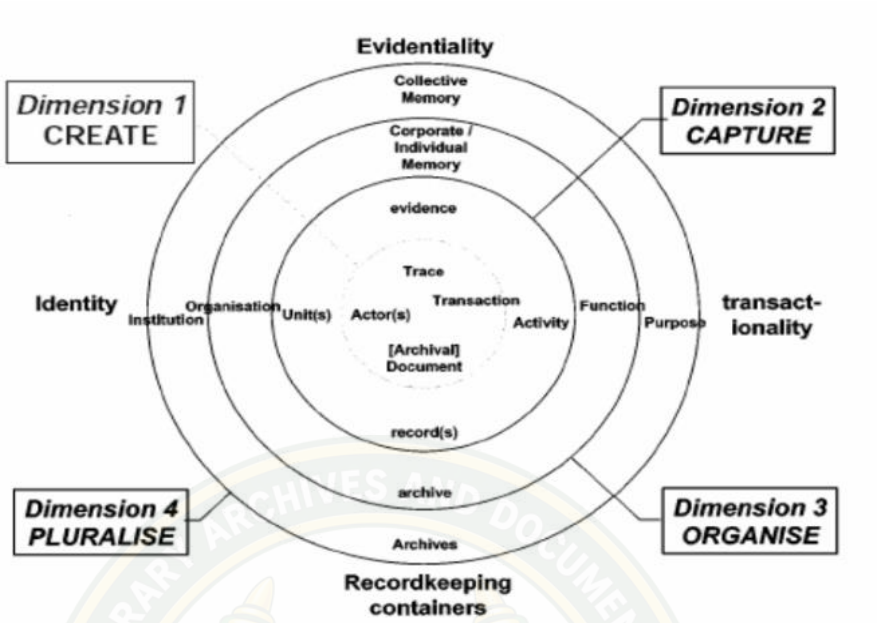
2.2 Theoretical Framework

This study is built on the basic principles of records management. The International Records Management Trust (IRMT, 1999) explains three main principles: records must be kept together according to the office that is responsible for them; they must stay in the order they were created; and they pass through a life cycle of current, semi-current, and non-current use before they are finally disposed of. Ngulube and Tafor (2006) add that records management means controlling records from the time they are created until they are disposed of, with the goal of keeping them safe while making sure they are available in the right format, to the right people, at the right time. This matters most in hospitals, because health institutions deal directly with people's lives. Good records management helps medical records to be found quickly, which supports quality service delivery (IRMT, 1999). The IRMT (1999) further states that good records management supports good medical care: when records are correct, complete, and easy to access, health workers can make informed decisions, but when records are incomplete or hard to find, mistakes such as wrong diagnosis can happen.

The older Records Life Cycle Model, which treats records management as a fixed set of stages ending in disposal, was later criticised for not being able to handle electronic records, which depend on hardware and software that keep changing (Bantin, 2008). Because of this weakness, the Records Continuum Model, developed by Frank Upward (1996), was chosen as the main theory for this study.

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Figure 2.1: The Records continuum model. (Upward, 2000, p.123)



The continuum model is commonly represented through four dimensions that operate simultaneously rather than sequentially: Create, the point at which a record comes into existence as a trace of an action; Capture, the point at which it is incorporated into a recordkeeping system; Organise, the point at which it becomes part of an organisation's accumulated memory; and pluralize, the point at which it becomes part of collective or societal memory (Upward, 1996). For a patient's medical record, this means the record is not simply created once and stored, but continues to acquire new layers of context and use, from the clinical encounter itself, to its place within the hospital's records system, to its potential use in research or health planning, as illustrated in Figure 2.1.

Alongside these four dimensions, the IRMT (2000) describes the coordinated activities that keep the continuum functioning in practice: identifying the record, keeping intellectual control over it, giving access to it, and keeping physical control over it. Rather than treating recordkeeping as a series of separate stages, as the life cycle model does, the continuum model views it as something ongoing. Flynn (2001) describes the continuum as a way of managing records consistently from the moment they are created to the moment they are preserved. McKemmish (1997) describes it as a model that looks at records from many angles at once, comparing it to a beam of light that can be separated into different colours while still being one connected beam. Medical records hold sensitive patient information

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that is needed for clinical decisions (Marutha, 2017). The continuum model makes sure that records are captured, managed, kept safe, and available as evidence for as long as they are needed. Shepherd and Yeo (2003) note that the model was developed between the 1980s and 1990s as a response to the life cycle model's failure to handle digital records properly. The continuum model also connects records management to accountability, whether corporate, social, cultural, or historical, treating records as valuable assets of an organisation (Upward, 2000).

2.2.1 Relationship of the Continuum Model to this Study

This study uses the Records Continuum Model as its guiding framework for managing patients' medical records. The model was chosen because it does not treat records as documents that simply move from creation to storage and then to destruction. Instead, it treats records as things that stay useful and meaningful over time. The continuum model helps make sure that the meaning, context, accessibility, and evidential value of medical records are kept and protected over time. From the moment a record is created, it starts serving more than one purpose. A patient's medical record, for example, is not only used to guide treatment but can also support medical research. This model was chosen because it offers one consistent way of managing a record from the time it is created to the time it is preserved, treating record-keeping as a continuous flow of connected activities (McKemmish, 1997).

Medical records play an important human role in healthcare. They are kept so that clinical information can be shared among health workers and so that service delivery can be efficient and effective. They are often the most reliable source of information available to decision-makers when planning future health services, and they are costly to produce, for example X-rays and laboratory results, which makes managing them properly even more important. As the IRMT (1999) states, hospitals deal directly with matters of life and health, so good record-keeping is not optional but essential. Health workers cannot give the best possible treatment without accurate patient information, and where proper records are missing, misdiagnoses or wrong treatment can result. The continuum model therefore offers a broad and practical framework for examining how medical records management supports healthcare service delivery at Bagamoyo District Hospital. Applied specifically to this study's objectives, the continuum model helps explain why weaknesses at one point in the record's life affect every other point: gaps in how records are created (Objective One) limit

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how well they can later be organised and retrieved; inadequate infrastructure (Objective Two) interrupts the movement of a record between the electronic and physical dimensions of the continuum; and the resulting challenges (Objective Three) can therefore be understood not as separate problems but as breaks in an otherwise continuous process that should keep the record usable, accurate, and accessible throughout its existence.

2.3 Empirical Literature Review

Several studies have looked at medical records management in different hospital settings, and their findings help to explain the practices, infrastructure, and challenges relevant to this study.

2.3.1 Medical Records Management Practices

Marutha (2016) studied medical records management practices in African public hospitals and found that most facilities still depended heavily on manual filing, with little standard procedure for creating, updating, or retrieving patient information. WHO (2021) looked at the role of medical records in clinical decision-making and found that complete and correct records are needed for health workers to make informed decisions and keep patients safe. Kilonzo et al. (2023) studied Tanzanian district hospitals and found that many facilities still depend on paper-based practices even where electronic systems have been partly introduced, which results in staff recording information in different ways. The Tanzania Ministry of Health (Kilonzo et al., 2023) also found that health workers rely heavily on documented patient information, and that keeping records in a consistent way is important for continuity of care. On this point, Edward and Sukums (2022), in a qualitative study conducted at Meru District Hospital in Arusha, found that the Government of Tanzania Hospital Management Information System (GoTHOMIS) had only been partially implemented and used, largely because a top-down approach to adoption limited the preliminary preparations made by the hospital before the system was rolled out. This implies that even where hospitals are provided with electronic recordkeeping tools, actual day-to-day practice may remain inconsistent unless staff are adequately prepared and involved in the process, a pattern that is likely to be relevant to district hospitals such as Bagamoyo District Hospital.

2.3.2 Infrastructures for the management of Medical Records

Campanella et al. (2016) found that having reliable infrastructure, both storage space and electronic systems, has a direct effect on how complete and accessible medical records are.

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Kruse et al. (2016, 2018) studied the effect of infrastructure on records management and found that poor storage space and weak information and communication technology (ICT) infrastructure lead to overcrowding, misplaced files, and slow retrieval, while well-set-up electronic systems save space and speed up retrieval where they are properly implemented. The International Records Management Trust (IRMT, 1999) recommended that hospitals set aside enough space for registration, filing, shelving, and secure storage close to service points, with controlled access to protect patient privacy. Were et al. (2019) found that poorly planned storage areas make organising and retrieving records harder as the number of records grows over time, while Alotaibi and Federico (2017) found that using health information technology well depends on having enough infrastructure, trained staff, and steady funding. In the same regard, Mwogosi and Mambile (2025), in a survey of public primary healthcare facilities across Tanzania, found that inadequate infrastructure, frequent power interruptions, and duplication of effort were among the main factors limiting the effective use of electronic health record systems, even in facilities where such systems had already been introduced. Similarly, Nuwas et al. (2023), studying the implementation of an electronic medical record system at a regional referral hospital in northern Tanzania, found that inadequate information technology equipment was among the key barriers to effective system use, despite the recorded improvements in efficiency and resource management that the system brought. These findings suggest that infrastructural readiness, rather than the mere presence of a system, largely determines whether medical records can be properly stored, secured, and retrieved in Tanzanian public hospitals.

2.3.3 Challenges affecting medical records management

Mathabeni-Bokwe (2015) and Luthuli (2017), in separate studies carried out in South African hospitals, found missing, misfiled, or duplicate patient files, slow retrieval, and lack of storage space as common problems that weaken the completeness of patient information. Kruse et al. (2016) also found that high costs, resistance to change, and poor staff training make it harder for hospitals to adopt electronic health records successfully. Ojo and Popoola (2015) studied developing countries and found that poor infrastructure and weak enforcement of records policies often lead to incomplete and hard-to-find records, which slows down service delivery. Tsai et al. (2020) looked at interoperability between hospital systems and found that when systems are not connected to each other, this causes duplicate and inconsistent patient data. Boonstra et al. (2017) studied the adoption of digital

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recordkeeping and found that worries about privacy and data security still slow down the move to electronic systems in many health facilities. Within the Tanzanian context specifically, Nuwas et al. (2023) identified inadequate staff training and insufficient funding as the leading challenges affecting electronic medical record implementation at Haydom Lutheran Hospital, while Edward and Sukums (2022) similarly found that inadequate ICT knowledge and skills among users, together with insufficient management support for infrastructure, training, and supervision, were the main barriers preventing hospital staff from effectively using GoTHOMIS at Meru District Hospital. Taken together, these findings suggest that the challenges affecting medical records management in Tanzanian public hospitals are not only technical but also relate to staff capacity, funding, and organisational support, all of which are relevant considerations for this study at Bagamoyo District Hospital.

2.4 Research Gap

The literature reviewed above leaves at least three gaps unanswered. On content, the newest Tanzanian studies on GoTHOMIS, including Edward and Sukums (2022) at Meru District Hospital and Nuwas et al. (2023) at a referral hospital in the north, mainly ask whether staff use the electronic system, without looking at the wider set of records management practices, infrastructure, and day-to-day problems, such as filing, tracing files, and opening new files, that decide whether such a system actually improves service delivery. On setting, the broader frameworks built by Marutha (2016) and Marutha and Ngoepe (2018) came from provincial hospitals in South Africa, while the Tanzanian GoTHOMIS studies were done at referral and primary-care facilities; a small district hospital with only one Medical Records Officer, such as BDH, is not close enough to either of these settings for their findings to apply directly. This creates a timeline gap too: the most relevant Tanzanian evidence is recent (2022–2025), but it comes from other facilities, so it cannot be assumed to describe what is happening at BDH today. Together, these gaps in content, setting, and timeline point to a gap in findings: no study has yet reported, with evidence, on medical records management practices, infrastructure, and challenges, and how these relate to service delivery, at a Tanzanian district hospital such as Bagamoyo District Hospital. This is the gap the present study was designed to address.

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2.5 Conceptual Framework

A conceptual framework refers to a structured representation of the relationship between variables that guide a research study. It explains how the independent variable is expected to influence the dependent variable and provides a logical foundation for the investigation. This framework is drawn directly from the title of the study, which links effective medical records management to improved service delivery. The independent variable is Medical Records Management Practices, encompassing records creation, storage and retrieval, and the use of information and communication technology (ICT), such as GoTHOMIS. Security and confidentiality are recognized in the literature as an important dimension of records management practice, but this study's empirical focus, in line with its data collection instruments, is on records creation, infrastructure, and the challenges affecting practice; security and confidentiality are therefore discussed only where they arise incidentally within these three areas, rather than examined as a separate, directly measured indicator. The dependent variable is Service Delivery in Public Hospitals, reflected through indicators such as timeliness of care, accuracy of diagnosis and treatment, continuity of care, and patient satisfaction.

2.5.1 Relationship between Variables

The conceptual framework illustrates the direct relationship between the independent and dependent variables. When medical records are managed effectively, that is, when they are properly created, securely stored, easily retrievable, and supported by reliable ICT systems, healthcare workers are able to access accurate and complete patient information within a short time. This enables timely and informed clinical decisions, reduces the likelihood of medical errors, and supports continuity of patient care, all of which contribute to improved service delivery.

Conversely, weaknesses in medical records management, such as misfiling, delayed retrieval, incomplete documentation, or poor ICT support, are likely to slow down healthcare processes and negatively affect the quality of service that patients receive. On this basis, the study treats medical records management practices as the factor expected to influence, and service delivery as the outcome expected to be influenced, at Bagamoyo District Hospital, as illustrated in Figure 2.2.

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In the same way, although service delivery in the wider literature is often judged by timeliness of care, accuracy of diagnosis and treatment, continuity of care, and patient satisfaction, the tools used to collect data for this study were built mainly to capture continuity of care, through what respondents said about how missing files and the practice of opening new files affect a patient's medical history. Timeliness, accuracy of diagnosis and treatment, and patient satisfaction are kept in the conceptual framework as the wider outcomes that good records management is expected, in theory, to support, but they were not measured directly by this study's questionnaire or interview. The findings on service delivery presented in Chapter Four and discussed in Chapter Five should therefore be read as evidence about continuity of care above all, with the other outcomes only suggested by the findings, not tested directly.

INDEPENDENT VARIABLE	➜	**DEPENDENT VARIABLE**
Medical Records Management Practices		***Service Delivery in Public Hospitals***
• Records creation • Storage and retrieval • Use of ICT infrastructures		• Timeliness of care • Accuracy of diagnosis and treatment • Continuity of care • Patient satisfaction

Figure 2.2: Conceptual Framework

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CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the procedures that were followed in carrying out the study on medical records management and its effect on service delivery at Bagamoyo District Hospital (BDH). It covers the research type, research design, study area, target population, sample size, sampling techniques, data collection methods, sources of data, ethical considerations, and the manner in which the collected data was processed and analyzed.

3.1 Research Type

A descriptive research type was adopted for this study. According to Kothari and Garg (2014), descriptive research is concerned with describing a situation or phenomenon as it exists at the time of the study, rather than manipulating variables to establish cause and effect. This type of research suited the present study because the researcher's interest was to describe, as accurately as possible, how medical records are currently managed at Bagamoyo District Hospital, what infrastructure is available for that purpose, and what challenges the hospital's staff encounter in the process, without attempting to alter any of these conditions.

3.2 Research Design

A research design is the overall plan that links the research questions of a study to the data that will be collected and the way that data will be analysed (Kothari & Garg, 2014). A cross-sectional descriptive design was used in this study, meaning that data on medical records management practices, infrastructure, and challenges at Bagamoyo District Hospital were collected once, from different categories of respondents, within a single, defined period. This design was considered appropriate because it allowed the researcher to capture a snapshot of the current state of medical records management at the hospital, combining both numerical and narrative data, without requiring repeated visits over an extended time.

3.3 Study Area

The study was conducted at Bagamoyo District Hospital, a public healthcare facility located at Dunda ward, Bagamoyo District, Pwani region, Tanzania. Established on July 1,1895,

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during the colonial era, the hospital currently operates under the Local Government (District Authority) Act cap. 287 and the National Health policy of the Ministry of Health which govern the administration of district level public health facilities in Tanzania.Three considerations informed the choice of this hospital as the study area. First, its proximity to the researcher made repeated visits for data collection practical within the time and resources available. Second, the hospital hosts the specific categories of respondents required for this study, namely medical records staff, healthcare providers, and administrative staff, all of whom interact with patient records in the course of their duties. Third, the hospital maintains records and internal documentation directly relevant to the study topic, which made it a suitable setting for examining medical records management and its link to service delivery.

3.4 Target Population

A target population is the entire group of individuals from which a researcher seeks to draw information for a study (Bryman, 2012). The target population for this study consisted of healthcare workers at Bagamoyo District Hospital who are directly involved in creating, handling, managing, accessing, or supervising medical records. Five categories of staff were covered: doctors, nurses, ward clerks, patient administration staff, and Medical Records Officers (MROs) or Assistant Medical Records Officers (AMROs).

3.5 Sample Size

Sample size refers to the actual number of respondents drawn from the target population to participate in a study (Kothari & Garg, 2014). A total of 25 respondents were selected from the 46 members of the target population, comprising 8 doctors, 10 nurses, 3 ward clerks, 3 patient administration staff, and 1 Medical Records Officer. These respondents were selected because their day-to-day duties gave them direct and sufficiently informed exposure to medical records management practices at the hospital.

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Category of Respondents	Population	Sample Size	Percentage (%)
Doctors	16	8	32%
Nurses	20	10	40%
Ward Clerks	3	3	12%
Patient Admin Staff	6	3	12%
Medical Records Officer (MRO)/AMRO	1	1	4%
Total	46	25	100%

Table 3.1: Sample Size — Source: Researcher (2026)

3.6 Sampling Techniques

Sampling techniques are the procedures researchers use to draw a manageable sample that still reflects the characteristics of the wider population (Kothari & Garg, 2014).Msabila and Nalaila (2013) similarly observe that the appropriate use of sampling techniques enables a researcher to study a smaller, manageable group of respondents while still generating findings that can reasonably be related to the wider population, a consideration that was particularly relevant to this study, which drew only 25 respondents from a target population of 46 staff. Both probability and non-probability sampling were used to select respondents for this study.

3.6.1 Probability Sampling

Probability sampling gives every member of the population a known and, in most cases, an equal chance of being included in the sample, typically through random selection (Kothari & Garg, 2014). In this study, random selection was used to draw doctors and nurses from their respective departments, reducing the chance that the researcher's own judgement would influence who was included.

3.6.2 Non-Probability Sampling

Non-probability sampling, by contrast, does not give every member of the population an equal or known chance of selection; instead, respondents are chosen based on criteria set by the researcher (Kothari & Garg, 2014). This study applied purposive (judgemental) sampling to select the Medical Records Officer and specific ward clerks and administrative staff, on the basis of their position, level of experience, and direct responsibility for medical records, since these respondents were best placed to provide informed answers on the study objectives.

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3.7 Data Collection Methods

Data collection methods are the specific tools and procedures used to gather information needed to answer a study research questions (Saunders, Lewis & Thornhill, 2019). Both primary and secondary data collection methods were used in this study.

3.7.1 Primary Data

Primary data is information gathered directly by the researcher for the specific purposes of the study at hand (Kothari & Garg, 2014). Two methods were used to collect primary data in this study: questionnaires and interviews.

3.7.1.1 Questionnaires

Structured questionnaires containing closed-ended items were administered to healthcare providers and records staff at Bagamoyo District Hospital. The questionnaire items were developed directly from the study's three specific objectives and focused on current medical records management practices, the infrastructure available for managing patient records, and the challenges affecting medical records management at the hospital. Within the section addressing challenges, each item on a specific challenge was immediately followed by a corresponding item asking the respondent to suggest a measure to address that same challenge, so that the two sets of responses could be directly linked and compared during analysis.This method was considered advantageous for the study because it allowed data to be collected simultaneously from a relatively large number of respondents across different professional categories within a short period, while also giving respondents adequate privacy and time to consider their answers to closed-ended items, thereby improving the reliability of the numerical data used to address the first two objectives of the study.

3.7.1.2 Interviews.

Semi-structured interviews were conducted with the Medical Records Officer as a key informant, allowing the researcher to probe for detail and context that a structured questionnaire could not capture, particularly on how records management practices, infrastructure, and challenges affect the delivery of healthcare services at the hospital (Kothari & Garg, 2014).The use of an interview was advantageous to this study because it allowed the researcher to seek clarification and follow up on responses in real time, generating richer, context-specific information from the Medical Records Officer than a

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structured questionnaire alone could provide, particularly on how records management practices and challenges relate to service delivery.

3.7.2 Secondary Data

Secondary data is information that was originally collected for a purpose other than the current study but is drawn upon to support it (Saunders, Lewis & Thornhill, 2019). In this study, secondary data was obtained through document review.

3.7.2.1 Document Review

Journal articles, dissertations, and previous research reports related to medical records management were reviewed. This helped the researcher to situate the findings of this study within existing knowledge, strengthen the literature review in Chapter Two, and compare the findings obtained at Bagamoyo District Hospital with those reported in other settings.Reviewing previous studies and related documents was beneficial to this study because it saved time and costs by using already published information. It also helped the researcher identify the research gap addressed by this study, compare the findings with those of previous studies, and improve the credibility of the findings by verifying information from different sources.

3.8 Sources of Data

3.8.1 Primary Data Sources

Primary data was obtained directly from healthcare providers and records staff at Bagamoyo District Hospital through questionnaires and interviews, providing first-hand information on medical records management practices, infrastructure, and challenges at the hospital.

3.8.2 Secondary Data Sources

Secondary data was drawn mainly from previously published research, including journal articles, dissertations, and research reports on medical records management, as well as from internal hospital documents such as patient registers, hospital reports, and policy documents. This information supported and contextualised the primary data collected from respondents.

3.9 Ethical Considerations

Research ethics are the moral principles and professional standards that guide the conduct of a study, protecting the rights, dignity, privacy, and welfare of participants while upholding honesty and transparency throughout the research process (Creswell, 2018).Msabila and

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Nalaila (2013) similarly stress that safeguarding the confidentiality, voluntary participation, and informed consent of respondents is a fundamental requirement of any credible research conducted within the Tanzanian academic context, a principle that guided the researcher's conduct throughout data collection at Bagamoyo District Hospital (BDH). Before data collection began, the researcher obtained an official introduction letter from the Research Department of the School of Library, Archives and Documentation Studies (SLADS), which was submitted to the relevant hospital authorities for approval. Informed consent was sought from each participant after the purpose of the study had been explained. Confidentiality was maintained by not recording participants' names, participants were informed of their right to withdraw at any time, and all information collected was used strictly for academic purposes.

3.10 Data Processing and Analysis.

Data analysis involves systematically examining collected facts and figures using appropriate techniques in order to draw conclusions on the questions guiding a study (Kothari & Garg, 2014). Data collected in this study was analysed through statistical description and content analysis. Quantitative responses were edited, coded, tabulated, and converted into percentages to allow meaningful comparison across categories of respondents, while qualitative responses obtained from the interview were analysed through content analysis, organised around the three specific objectives of the study.

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CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents, analyzes, and discusses the findings of the study on the effectiveness of medical records management in improving service delivery at Bagamoyo District Hospital (BDH). The chapter is organized into three main sections: the response rate and demographic characteristics of the respondents, the presentation and discussion of findings based on the study objectives, and the interpretation of the findings in relation to the reviewed literature. The findings are presented using tables and supported by interview responses where appropriate.

4.1 Response Rate

This section presents the response rate of the questionnaires that was distributed to the respondents during data collection process.

Response rate is an important measure in research as it indicates the level of respondent's participation and reflect the reliability of the data collection for analysis. In this study, a total of 25 questionnaires were distributed to the sampled respondents at Bagamoyo District Hospital. Table 4.1 below presents a summary of the questionnaires distributed and returned.

Table 4.1: Response rate (N=25)

Category	Frequency	Percentages (%)
Questionnaires distributed	25	100%
Questionnaires returned	25	100%
Questionnaires not returned	0	0

Source: Field Data (2026)

A response rate of 100% means that every person selected for the study took part, so no group of staff was left out of the results. This full participation was mainly possible because the questionnaires were handed out and collected in person during working hours, and because respondents had a direct, everyday connection to the subject of the study. Mugenda

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and Mugenda (2003) consider a response rate above 70 percent to be excellent for academic research, so the 100% achieved here goes beyond that standard and gives a strong basis for the analysis that follows in this chapter. A response rate this high also matters for a smaller study of this kind, where the total sample was only 25 respondents drawn from a wider population of 46 staff. In a small sample, even one or two missing questionnaires can noticeably change the percentages reported in later sections of this chapter. Because every questionnaire was returned, the percentages presented from Section 4.2 onwards are based on complete information from the whole intended sample, rather than on an incomplete or partial picture of staff opinion at Bagamoyo District Hospital.

4.2 Section A: Demographic Characteristics of the Respondents

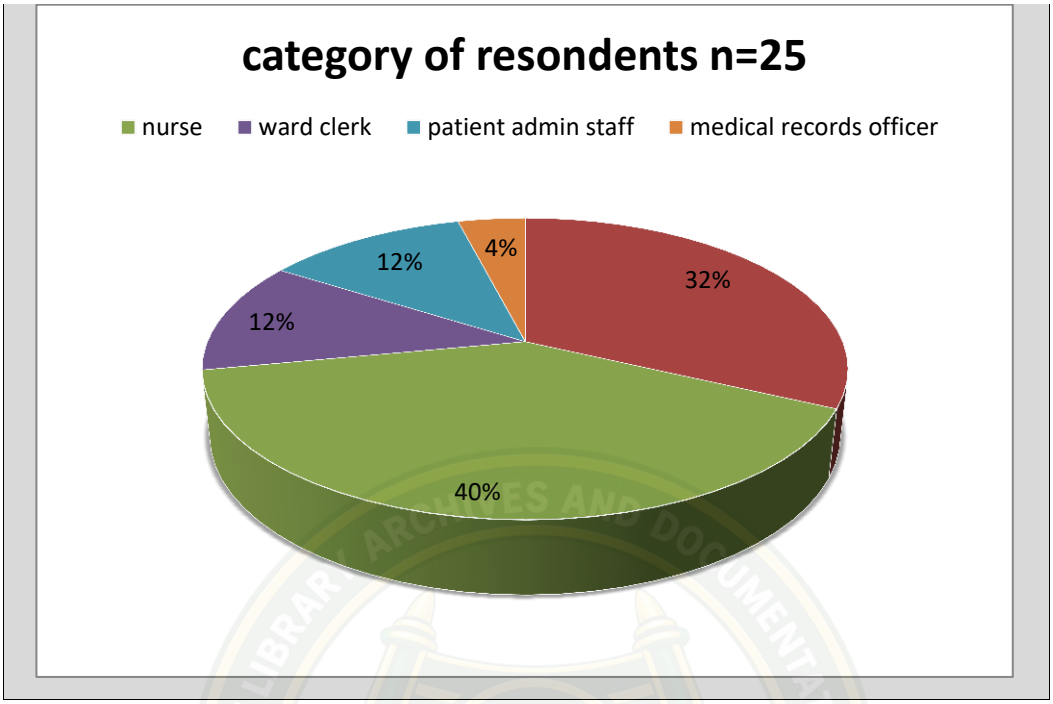
This section presents the demographic characteristics of the respondents, namely their professional category, level of education, and years of work experience. These characteristics were considered important because they provide a context for interpreting the respondents' knowledge and opinions on medical records management practices at BDH.

4.2.1 Category of Respondents

Figure 4.1 shows that nurses formed the largest proportion of respondents at 10 (40%), followed by doctors at 8 (32%). Ward clerks and patient administration staff each accounted for 3 (12%) of the respondents, while the Medical Records Officer (MRO) accounted for only 1 (4%). The dominance of nurses and doctors reflects the fact that these cadres interact with patient records most frequently in the course of clinical work, while the presence of only one MRO already signals the shortage of qualified records personnel that is discussed further under Objective Three of this study.

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Figure 4.1: Category of respondents



Source: Field Data (2026)

4.2.2 Education Level of the Respondents

Respondents were also asked about their highest level of education, in order to judge whether they had enough professional background to give informed views on medical records management practices and challenges. Most respondents, 13 (52%), held a Diploma, followed by those with a Bachelor's Degree, 6 (24%), and those with a Master's Degree, 5 (20%). Only 1 (4%) respondent had a Certificate as the highest qualification.

Table 4.2: Education level of the respondents (N=25)

Education Level	Frequency	Percentage (%)
Certificate	1	4%
Diploma	13	52%
Bachelor's Degree	6	24%
Master's Degree	5	20%
Total	**25**	**100%**

Source: field data 2026

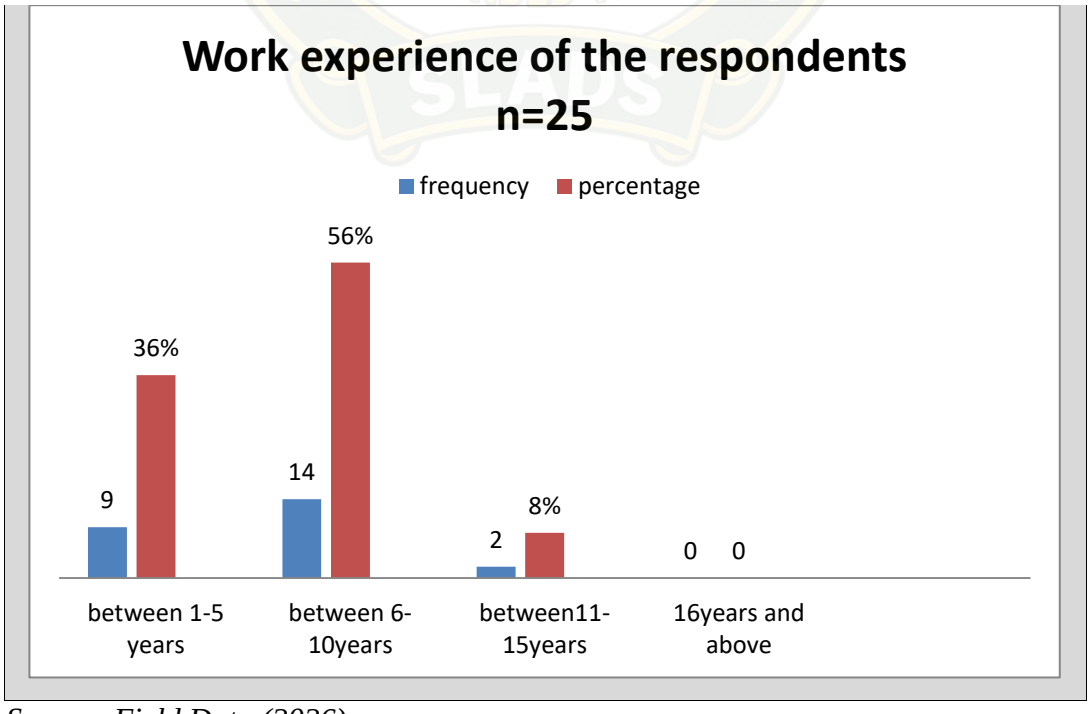
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Since most respondents held a Diploma or a higher qualification, it is reasonable to conclude that they had enough professional training to understand records management procedures and to give thoughtful opinions on the challenges facing the hospital. This matches what Katuu (2016) found, that staff in many African public hospitals usually hold at least a diploma-level qualification, even though specific training in records management itself often remains limited, a gap that becomes clearer later in this chapter. It is worth pointing out, however, that holding a Diploma or Degree in a clinical field, such as nursing or medicine, is not the same as being trained in records management specifically. Most respondents were qualified in their own clinical or administrative profession rather than in records and archives management, which means their views on records practices, while informed by daily experience, are the views of end users of the records system rather than of trained records professionals.

4.2.3 Work Experience of the Respondents

The participants were also asked to indicate their level of work experience at the hospital, as presented in Figure 4.2.

Figure 4.2: Work experience of the respondents (N=25)



Source: Field Data (2026)

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Figure 4.2 shows that the majority of respondents, 14 (56%), had worked at the hospital for between 6 and 10 years, while 9 (36%) had between 1 and 5 years of experience. A smaller proportion, 2 (8%), had between 11 and 15 years of experience, and none of the respondents had 16 years of experience or more. This implies that most respondents had served long enough to be well acquainted with the medical records management practices, infrastructure, and challenges at Bagamoyo District Hospital, which increases the credibility of the information they provided.

4.3 Section B: Current Medical Records Management Practices at Bagamoyo District Hospital

This section presents and discusses findings in relation to the first objective of the study, which sought to examine the current medical records management practices at Bagamoyo District Hospital. Findings from the questionnaires are presented together with the corresponding responses obtained from the interview with the Medical Records Officer (MRO).

4.3.1 Medical Records Creation

Respondents were asked to describe how medical records are created at the hospital. As shown in Table 4.3, 20 (80%) of the respondents indicated that medical records are created through both electronic and manual procedures, while 5 (20%) did not respond to the question, largely because record creation falls outside their direct daily duties.

Table 4.3: Medical records creation (N=25)

Medical Records Creation	Frequency	Percentage (%)
Both electronically and manually	20	80%
No response	5	20%
Total	**25**	**100%**

Source: Field Data (2026)

To verify this finding, the researcher interviewed the Medical Records Officer (MRO), who was asked how medical records are created at the hospital. The MRO explained:

> *Patient records are first created electronically through GoTHOMIS, where demographic information is entered and a unique patient identification number is generated. After registration, a physical patient file is opened to record all clinical information throughout the patient's treatment process.*

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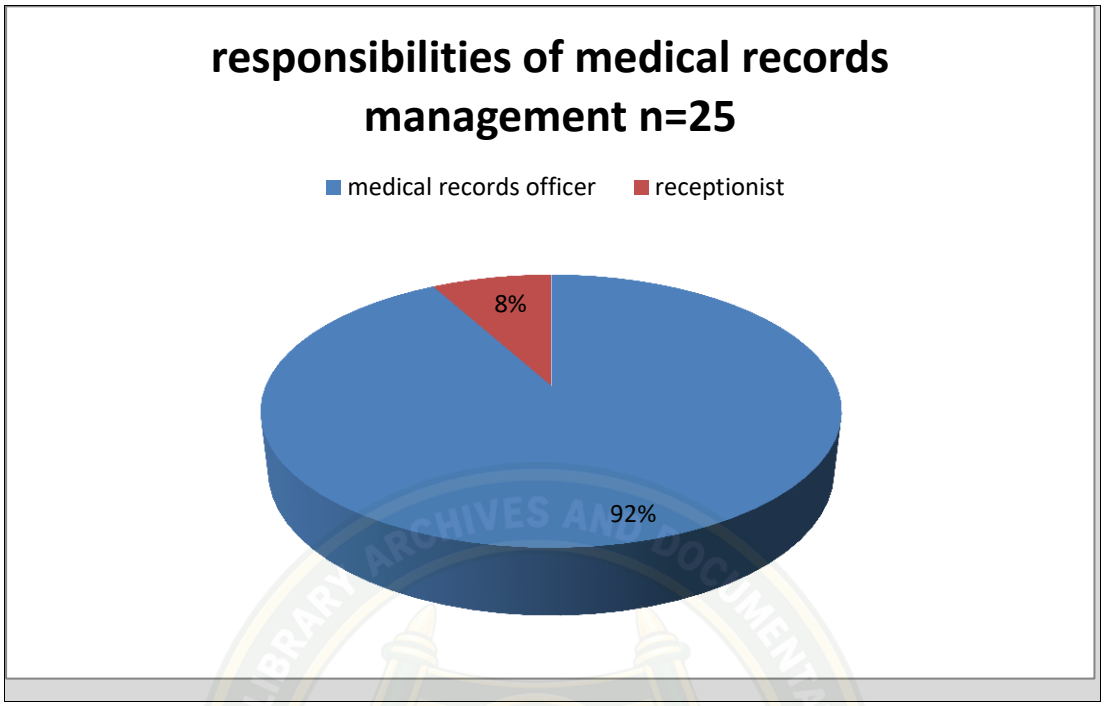
The questionnaire and interview findings are therefore consistent and confirm that Bagamoyo District Hospital operates a hybrid medical records management system in which the Government of Tanzania Hospital Management Information System (GoTHOMIS) is used for electronic registration, while a parallel physical file is maintained for clinical documentation. This practice is in line with the Ministry of Health (MoH, 2021) guideline, which recommends electronic patient registration through GoTHOMIS alongside the maintenance of physical files to support continuity of patient care. The finding also affirms the observation of Katuu (2016) and Marutha and Ngoepe (2018) that many African public hospitals continue to rely on hybrid systems rather than fully electronic records, owing to infrastructural and resource limitations. Viewed through the Records Continuum Theory discussed in Chapter Two, this two-step creation process marks the point at which a record enters the continuum split into two versions, electronic and physical, that must stay consistent with each other for the whole of the patient's care.

4.3.2 Responsibility for Medical Records Management.

Respondents were further asked to indicate who is primarily responsible for managing medical records at the hospital. Figure 4.3 shows that the overwhelming majority, 23 (92%), identified the Medical Records Officer (MRO) as the responsible officer, while 2 (8%) mentioned the receptionist. None of the respondents attributed this responsibility to nurses or doctors.

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Figure 4.3: Responsibility for medical records management (N=25)



Source: Field Data (2026)

This finding was corroborated by the interview, during which the MRO was asked who is responsible for the overall management of medical records and what their roles entail. The MRO responded:

> *The overall responsibility for the management of medical records lies with the Medical Records Officer (MRO). The MRO is responsible for coordinating records management activities, including records creation, classification, indexing, filing, storage, retrieval, and ensuring the confidentiality and security of patient information. The MRO also supervises medical records staff, monitors compliance with records management procedures, and ensures that patient records are properly maintained to support effective healthcare service delivery.*

This finding confirms the centrality of the Medical Records Officer's role, as emphasised in the conceptual framework in Chapter Two, which identifies records management practices, including staff responsibility for records handling, as a key determinant of accurate, complete, and confidential records. However, the fact that only one Medical Records Officer, as shown in Figure 4.1, is designated to coordinate all these functions raises concern about workload and capacity, a matter that is further examined under the challenges facing records management in Section 4.5.

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4.3.3 Creation of a New Patient File When the Old File Is Missing.

The study also sought to establish whether a new patient file is created whenever an old file cannot be traced. As presented in Table 4.4, the majority of respondents, 18 (72%), indicated that a new file is opened when the old one is missing, while 7 (28%) indicated that this is not the practice.

Table 4.4: Creation of a new patient file When the old file is missing (N=25)

Response	Frequency	Percentage (%)
Yes	18	72%
No	7	28%
Total	25	100%

Source: Field Data (2026)

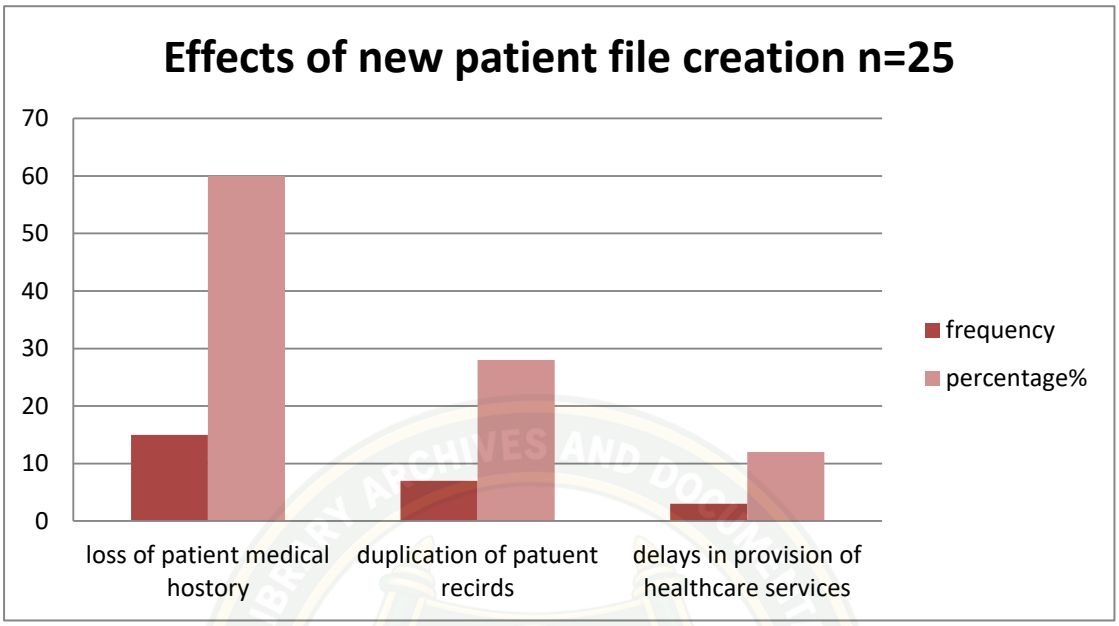
Opening a new file is a quick way to avoid delaying a patient's treatment when the old file cannot be traced, but it comes at a cost, since the new file does not carry forward the clinical details recorded in the missing one. The fact that almost three-quarters of respondents confirmed this practice suggests that tracing and retrieving files remains a real weakness in the hospital's records system. This finding matches the concern raised by Tsai et al. (2020), who found that a lack of connection between records systems often results in duplicate files and inconsistent patient information, a pattern that is clearly present at Bagamoyo District Hospital as well.

4.3.4 Effect of New Patient File Creation on Continuity of Healthcare Service

Building on the previous item, the questionnaire went on to ask all 25 respondents, regardless of their individual answer in Section 4.3.3, to explain what effect the practice of opening a new file has on continuity of patient care. This wider approach captured views from staff who had not personally come across a missing file but could still comment on its broader consequences. The majority, 15 (60%), pointed to loss of patient medical history as the main effect, 7 (28%) mentioned duplication of patient records, while 3 (12%) mentioned delays in providing healthcare services.

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Figure 4.4: Effect of new patient file creation on continuity of healthcare service (N=25)



Source: Field Data (2026)

Loss of patient medical history stood out as the biggest concern, which is worrying in a clinical setting because healthcare providers who do not know a patient's earlier diagnosis and treatment are more likely to repeat unnecessary tests or miss important clinical details. Duplication of records and delays in service, although mentioned less often, point to the same underlying problem of weak file tracing and retrieval already discussed above. These findings support the argument made by Marutha (2016) and Boonstra et al. (2017), that missing or poorly filed records put continuity of patient care at risk and increase the chance of clinical errors, since healthcare providers are forced to make decisions without the patient's complete history.

Taken together, the findings presented in this section describe a single connected chain rather than four unrelated issues. A weakness at the start of the chain, in how physical and electronic records are linked at the point of creation, works its way through to the end of the chain, in the form of lost patient history and possible harm to continuity of care, directly answering the first specific objective of this study.

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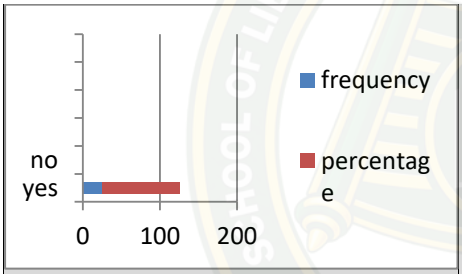
4.4 Section C: Infrastructure for Managing Medical Records at Bagamoyo District Hospital

This section presents and discusses findings related to the second objective of the study, which sought to assess the existing infrastructure for managing patient medical records at Bagamoyo District Hospital.

4.4.1 Availability of an Electronic Medical Records (EMR) System

To examine the availability of infrastructure for managing medical records, respondents were asked whether an Electronic Medical Records (EMR) system was available at Bagamoyo District Hospital. All 25 (100%) respondents who participated in the study confirmed the existence of an Electronic Medical Records (EMR) system at the hospital, as shown in Figure 4.5.

Figure 4.5: Availability of an Electronic Medical Records (EMR) System (N=25)



	Frequency	Percentage (%)
Yes	25	100%
No	0	0%
Total	25	100%

Source: Field Data (2026)

To gain a deeper understanding of how the EMR system is used, the MRO was asked whether an EMR system exists and how it is applied in managing medical records. The response was:

> *Yes, the hospital has an Electronic Medical Records (EMR) system. The EMR is available as a module within the Government of Tanzania Hospital Management Information System (GoTHOMIS), which is the hospital's Electronic Health Management System (EHMS). The hospital uses a hybrid medical records management system, where patient records are managed through both the electronic medical records system management module in GoTHOMIS and paper-based records. The electronic medical records system is used to capture, store, and manage patient information, while some records management activities, such as filing, storage, and retrieval of physical files, are still carried out manually.*

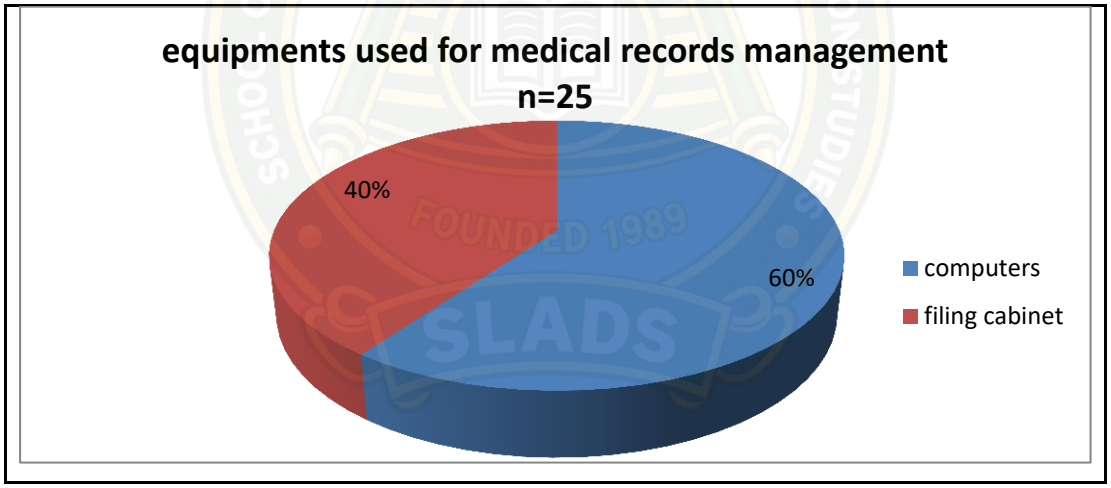
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Although the questionnaire results show universal (100%) awareness of the existence of an EMR system, the interview response reveals that its utilisation is only partial, being confined mainly to registration and selected clinical details, while filing, storage, and retrieval remain largely manual. This distinction between the availability and the actual utilisation of electronic infrastructure is consistent with WHO (2021), which cautions that the mere presence of an Electronic Medical Record system does not guarantee improved records management unless it is fully integrated into the hospital's daily workflow.

4.4.2 Equipment Used for Medical Records Management

To gain an understanding of the physical and technological infrastructure available for medical records management, respondents were asked to indicate the equipment used in managing medical records at the hospital. As shown in Table 4.6, 15 (60%) of the respondents mentioned computers, while 10 (40%) mentioned filing cabinets.

Figure 4.6: Equipment used for medical records management (N=25)



Source: Field Data (2026)

The fact that filing cabinets still feature prominently alongside computers confirms that the hospital operates a hybrid infrastructure rather than a fully digitised one. This finding echoes the observation of Kruse et al. (2016) and the International Records Management Trust (IRMT, 1999), which stress that adequate physical storage infrastructure, such as filing cabinets and shelving, remains indispensable in health facilities that have not yet achieved full electronic integration, and that both physical and electronic infrastructure must be adequately resourced to support effective records management.

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Viewed together, the findings in this section reveal a gap between the availability and the actual functioning of records infrastructure at Bagamoyo District Hospital. Within the Records Continuum Theory (Upward, 1996) discussed in Chapter Two, infrastructure is expected to support a record smoothly through each stage of its life, from creation to eventual use and disposal. At BDH, however, the continuum is interrupted immediately after creation: the EMR system captures the record electronically, but filing, storage, and retrieval revert to manual, cabinet-based processes. This break in the continuum, rather than a simple shortage of equipment, is what links the infrastructural findings of this section to the missing-file and lost-history problems already discussed under Objective One in Section 4.3.

4.5 Section D: Challenges Affecting Medical Records Management at Bagamoyo District Hospital

This section presents and discusses findings in relation to the third objective of the study, which sought to identify the challenges affecting the management of medical records at Bagamoyo District Hospital.

4.5.1 Challenges Facing Medical Records Management

The study further explored the challenges affecting the management of medical records at Bagamoyo District Hospital. Respondents were asked to indicate the challenges they experience in managing medical records, as shown in Table 4.5; the most frequently cited challenge was limited utilisation of the Electronic Records Management System (ERMS), reported by 12 (48%) of the respondents, followed by poor filing and retrieval systems, reported by 8 (32%), and shortage of trained records staff, reported by 5 (20%).

Table 4.5: Challenges facing medical records management (N=25)

Challenge	Frequency	Percentage (%)
Limited use of Electronic Records Management System (ERMS)	12	48%
Poor filing and retrieval system	8	32%
Shortage of trained staff	5	20%
Total	25	100%

Source: Field Data (2026)

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These findings were corroborated during the interview, when the MRO was asked to describe the challenges affecting the management of medical records at the hospital. The MRO stated:

> *Our hospital has made progress in improving medical records management through the use of a hybrid records management system that combines paper-based and Electronic Medical Records (EMR). However, we still experience some challenges, particularly limited utilisation of the EMR system in some records management activities. Some processes, including filing, storage, and retrieval of patient files, are still done manually due to gradual system implementation, available resources, and the need for continuous training and technical support. We also experience challenges related to storage space, shortage of trained medical records personnel, and increased workload. Despite these challenges, the hospital continues to improve the system to support effective healthcare service delivery.*

The convergence of the questionnaire and interview findings confirms that limited utilisation of the ERMS, weak filing and retrieval practices, and shortage of trained personnel are the principal challenges undermining medical records management at BDH. These findings are consistent with Ojo and Popoola (2015), who found that poor infrastructure and weak policy enforcement in developing countries result in incomplete and difficult-to-retrieve records, and with Kruse et al. (2016), who identified insufficient technical support and inadequate user training as key barriers to effective adoption of electronic health records. The shortage of trained staff is further underscored by the demographic finding in Figure 4.1, which showed that the hospital has only one Medical Records Officer, a staffing gap that inevitably limits the capacity to fully operationalise the ERMS and to enforce proper filing and retrieval procedures. Read against the Records Continuum Theory, these three challenges are not isolated technical problems but points at which the continuum breaks down: limited ERMS use disrupts the record at the point of capture, poor filing disrupts it at the point of storage and retrieval, and the shortage of trained staff removes the human capacity needed to hold the continuum together across all stages.

4.5.2 Measures to Improve Medical Records Management

Although the third objective of this study was limited to identifying the challenges affecting medical records management, the questionnaire also asked respondents to suggest a measure for each challenge they named, so that the recommendations in Chapter Five could be based

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directly on staff views rather than decided by the researcher alone. The findings in this subsection go a little beyond the third objective, but they support it directly.

Respondents were asked to suggest measures that could improve the management of patient medical records at Bagamoyo District Hospital. As shown in Table 4.6, 12 (48%) of the respondents recommended improving the filing and retrieval system, 8 (32%) recommended increasing the utilisation of the Electronic Medical Records (EMR) system, while 5 (20%) proposed recruiting and providing continuous training to medical records personnel.

Table 4.6: Measures to improve medical records management (N=25)

Suggested Measure	Frequency	Percentage (%)
Improve the filing and retrieval system	12	48%
Increase utilization of the EMR system	8	32%
Recruit and train medical records personnel	5	20%
Total	25	100%

Source: Field Data (2026)

It is worth noting that the pattern of responses in Table 4.6 corresponds exactly, in both frequency and percentage, to the challenges reported in Table 4.5. This is because the questionnaire item on suggested measures was placed directly beneath the item on challenges, with each respondent asked to propose a measure addressing the specific challenge they had just identified. A respondent who cited limited ERMS utilisation as a challenge, for example, correspondingly proposed increasing ERMS utilisation as the solution. This one-to-one correspondence between challenges and proposed measures, rather than indicating an error in data collection, reflects the paired structure of the questionnaire and confirms the internal consistency of respondents' views.

These suggestions match up directly with the three challenges identified earlier, which shows that respondents were not just describing problems in a general way but had clear ideas about how to solve them. It is notable that recruiting and training additional staff received the fewest mentions, even though staff shortage was identified as a real challenge; this may reflect that filing improvements and better use of existing technology feel like more immediate fixes to frontline staff, while recruitment is generally seen as a decision for hospital management. These recommendations agree with Marutha and Ngoepe (2018) and

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the IRMT (1999), who both stress that improving physical filing systems, strengthening the use of electronic infrastructure, and investing in the recruitment and training of skilled records staff are essential for improving medical records management and the quality of healthcare service delivery.

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CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of the study, the conclusion drawn from the findings discussed in Chapter Four, and the recommendations arising from the study. The chapter is organised into four sections: a summary of the study, a summary of the major findings in relation to the three specific objectives, the conclusion of the study, and recommendations addressed to hospital management, policy makers, and future researchers.

5.1 Summary of the Study

This study assessed the effectiveness of medical records management in improving healthcare service delivery at Bagamoyo District Hospital (BDH). The study was guided by three specific objectives: to examine the current medical records management practices at BDH, to assess the existing infrastructure for managing patient medical records at BDH, and to identify the challenges affecting medical records management at BDH. The study adopted a cross-sectional descriptive research design and a descriptive research type, which enabled the researcher to collect both qualitative and quantitative data at a single point in time. A sample of 25 respondents, comprising doctors, nurses, ward clerks, patient administration staff, and the Medical Records Officer (MRO), was selected using a combination of probability and non-probability (purposive) sampling techniques. Primary data were collected through structured questionnaires and semi-structured interviews, while secondary data were obtained through a review of hospital documents, policy manuals, and related literature. Data were analysed using statistical description, including frequencies and percentages, complemented by content analysis of the qualitative interview responses. All 25 questionnaires distributed were returned and analysed, giving a response rate of 100 percent.

5.2 Summary of the Major Findings

The major findings of the study are summarised below in accordance with the three specific objectives that guided the research.

5.2.1 Current Medical Records Management Practices at BDH

The study found that Bagamoyo District Hospital operates a hybrid medical records management system. Patient records are created electronically through the Government of

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Tanzania Hospital Management Information System (GoTHOMIS), which generates a unique patient identification number, after which a physical file is opened to document clinical information such as diagnosis, treatment, laboratory results, and follow-up visits. The overall responsibility for coordinating medical records management activities, including creation, classification, indexing, filing, storage, retrieval, and confidentiality, was found to rest almost entirely with the Medical Records Officer (MRO), as reported by 92.0 percent of respondents. The study further found that a new patient file is opened whenever an old file cannot be traced, a practice reported by 72.0 percent of respondents, and that this practice mainly results in loss of patient medical history (60.0 percent), duplication of patient records (28.0 percent), and delays in the provision of healthcare services (12.0 percent).

5.2.2 Infrastructure for Managing Medical Records at BDH

All respondents (100.0%) confirmed the availability of an Electronic Medical Records (EMR) system at the hospital. However, the interview with the MRO revealed that the utilisation of this system remains partial, being confined mainly to patient registration and selected clinical details, while filing, storage, and retrieval of physical patient files continue to be performed manually. This was reflected in the equipment used for records management, where 60.0 percent of respondents cited computers and 40.0 percent cited filing cabinets, confirming that the hospital's infrastructure remains a hybrid of electronic and manual systems rather than a fully digitised one.

5.2.3 Challenges Affecting Medical Records Management at BDH

The study identified three principal challenges affecting medical records management at BDH: limited utilisation of the Electronic Records Management System (ERMS), cited by 48% of respondents; poor filing and retrieval systems, cited by 32%; and shortage of trained medical records personnel, cited by 20%. These challenges were corroborated by the MRO, who attributed the limited use of the EMR system to inadequate infrastructure, limited resources, and insufficient user training, compounded by the fact that only one MRO is available to coordinate all records management functions at the hospital. Correspondingly, respondents proposed three main measures to address these challenges: improving the filing and retrieval system (48%), increasing the utilisation of the EMR system (32%), and recruiting and training additional medical records personnel (20.0 percent).

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5.3 Conclusion

Based on the findings presented in Chapter Four, the study concludes that medical records management at Bagamoyo District Hospital is only partially effective in supporting healthcare service delivery. While the hospital has made notable progress by adopting GoTHOMIS for electronic patient registration and by maintaining an EMR system, these gains are undermined by a continued heavy reliance on manual processes for filing, storage, and retrieval of patient records. The fact that records management responsibility rests with a single Medical Records Officer, together with the limited use of the available electronic infrastructure, appears alongside recurring practical problems reported by respondents, including duplicate patient files, loss of medical history, and delays in accessing patient information. Because this is a descriptive, cross-sectional study, it can show that these problems happen together, but it cannot prove that one causes the other; proving cause and effect would need a different kind of study, one that follows outcomes over time or compares hospitals with different levels of system use. Even with this limit in mind, the pattern found here matches the wider literature on medical records management in African public hospitals, and suggests that simply having an electronic system in place does not, by itself, seem enough to guarantee effective records management or better service delivery.

5.4 Recommendations

In light of the findings and conclusion of this study, the following recommendations are made.

5.4.1 Recommendations to Hospital Management

i. Hospital management should expand the utilization of the existing Electronic Medical Records (EMR) system beyond patient registration to cover filing, storage, and retrieval of clinical information, so as to reduce the hospital's continued dependence on manual processes.

ii. The hospital should recruit additional Medical Records Officers or Assistant Medical Records Officers to reduce the workload currently borne by a single officer and to strengthen supervision of records management activities across departments.

iii. Management should institute a clear policy and standard operating procedure for tracing and retrieving existing patient files before authorizing the creation of new ones, in order to minimize duplication of records and loss of patient medical history.

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iv. The hospital should improve its physical filing and storage infrastructure, including adequate shelving and secure filing cabinets, to support efficient organization and retrieval of records that are still maintained manually.

5.4.2 Recommendations to the Ministry of Health and Policy Makers

i. The Ministry of Health should allocate adequate resources to support full integration of GoTHOMIS and related electronic systems into all records management functions at district hospitals, rather than registration alone.

ii. Policy makers should establish and enforce minimum staffing standards for medical records personnel in public hospitals, commensurate with patient volumes, to address the shortage of trained records staff observed at Bagamoyo District Hospital and similar facilities.

iii. The Ministry of Health, in collaboration with training institutions, should organize continuous professional development and refresher training programs for records staff and other healthcare providers on both manual and electronic records management practices.

5.4.3 Areas for Further Research

This study was limited to the assessment of medical records management practices, infrastructure, and challenges at a single public hospital. Future researchers may wish to conduct a comparative study across several district hospitals in Tanzania to establish whether the findings of this study reflect a wider national pattern. Further research could also examine the cost-effectiveness and feasibility of transitioning fully from hybrid to electronic medical records systems in resource-constrained public hospitals, as well as investigate the perspectives of patients on how medical records management practices affect their experience of healthcare service delivery.

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APPENDICES

APPENDIX I: RESEARCH TIME SCHEDULE

Activities	**Jan–Feb 2026**	**Mar 2026**	**Apr 2026**	**May–Jul 2026**	**Aug 2026**
Writing of proposal					
Submission of proposal					
Reaching the study area and collecting data					
Report writing					
Submission of the research report					

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APPENDIX II: RESEARCH BUDGET

S/No	Item	Qty/Unit Cost (TZS)	Amount (TZS)
1	Preparation of Research Proposal		
	Pen	4 @ 500	2,000/=
	Printing (proposal)	42 pgs @ 200	8,400/=
	Binding of proposal	3 copies @ 2,000	6,000/=
	Data bundles	—	10,000/=
	Subtotal (Item 1)		26,400/=
2	Data Collection		
	Transport (to and from BDH)	—	25,000/=
	Printing of questionnaires	—	7,500/=
	Communication (airtime)	—	2,000/=
	Field allowance	—	12,000/=
	Research permit fee (BDH)	—	50,000/=
	Internet/data bundles	—	15,000/=
	Subtotal (Item 2)		111,500/=
3	Report Writing		
	Printing of report for corrections	—	7,500/=
	Printing of report (final copy)	—	15,000/=
	Binding of report	—	45,000/=
	Subtotal (Item 3)		67,500/=
	GRAND TOTAL		205,400/=

Source: Researcher (2026)

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APPENDIX III:

QUESTIONNAIRES FOR SAFF AT BAGAMOYO DISTRICT HOSPITAL (BDH).

Dear Respondent,

My name is Agustino Joseph Mkono. I am a College Student at the School of Library, Archives and Documentation Studies (SLADS). I am conducting a study titled: "**An Assessment on Effective Medical Records Management for Improving Service Delivery in Public Hospitals: A Case Study of Bagamoyo District Hospital**". This questionnaire is designed to facilitate the collection of information on what you know about the topic above. Your participation is voluntary and all responses will be treated with strict confidentiality and used only for academic purposes.

Please answer the following questions with honesty and to the best of your understanding.

SECTION A: RESPONDENT'S BACKGROUND INFORMATION

Please tick (√) the appropriate option or provide responses where necessary.

1. What is your job title in this hospital? (Tick one.)

A. Doctor ( )

B. Nurse ( )

C. Ward Clerk ( )

D. Patient Administration Staff ( )

E. Medical Records Officer (MRO) ( )

F. Other (Specify) ..... ( )

2. What is your highest qualification? (Tick one.)

A. Certificate ( )

B. Diploma ( )

C. Bachelor's degree ( )

D. Master's Degree ( )

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E. Other (Specify) ..... ( )

3. How long have you been employed in this hospital? (Tick one.)

A. 1–5 years ( )

B. 6–10 years ( )

C. 11–15 years ( )

D. More than 15 years ( )

SECTION B: MEDICAL RECORDS MANAGEMENT PRACTICES.

4. How are medical records created or received in this hospital?

……
.....
.....
.....

5. Who is responsible for the overall management of medical records in this hospital? (Tick one.)

A. Nurse ( )

B. Records Officer ( )

C. Receptionist ( )

D. Doctor ( )

6. Is it appropriate to create a new patient file when the old file cannot be found? (Tick one.)

A. Yes ( )

B. No ( )

7. If yes, what effect does it have on the continuity of healthcare service delivery?

A. Loss of patient medical history

B. Duplication of patient records

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C. Delays in provision of healthcare service

D. Poor continuity of healthcare and quality

E. No effect

SECTION C: INFRASTUCTURES FOR MANAGEMENT OF MEDICAL RECORDS

8. Is there an Electronic Medical Records (EMR) system in use at this hospital?

A. Yes ( )

B. No ( )

9. Which of the following equipment are used for the storage and management of medical records at this hospital? (Tick all that apply.)

A. Filing cabinets ( )

B. Computers ( )

C. Shelves/Racks for file storage ( )

D. Electronic Medical Records (EMR) system ( )

SECTION D: challenges affecting medical records management at Bagamoyo District Hospital (BDH).

10. Which of the following challenges affect medical records management at Bagamoyo District Hospital (BDH)? (Tick all that apply.)

A. Inadequate storage space ( )

B. Loss or misplacement of files ( )

C. Shortage of trained staff ( )

D. Poor filing and retrieval system ( )

E. Limited use of the Electronic Medical Records (EMR) system ( )

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11. Suggest measures that can be taken to improve the management of patient medical records at Bagamoyo District Hospital.

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APPENDIX IV

INTERVIEW GUIDE

12. Is there an Electronic Medical Records (EMR) system in use in this hospital?

13. If yes, please explain how it is used in managing medical records?

14. How are medical records created or received in this hospital from the point of patient registration to storage?

15. Who is responsible for the overall management of medical records in this hospital, and what are their roles?

16. What challenges are affecting the management of medical records in this hospital

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APPENDIX V:

APPROVAL LETTER

JAMHURI YA MUUNGANO WA TANZANIA

OFISI YA WAZIRI MKUU
TAWALA ZA MIKOA NA SERIKALI ZA MITAA

HALMASHAURI YA WILAYA BAGAMOYO

Unapojibu tafadhali taja

Kumb Na. JB.3411/375/01/342 **Tarehe**: 04 Mei, 2026

Mkuu wa Chuo,
Chuo cha Ukutubi na Uhifadhi wa Nyaraka,
Ukuni,
Plot 96,
S.L.P 227,
BAGAMOYO - PWANI.

Yah: **RUHUSA YA KUFANYA UTAFITI NDUGU AGUSTINE J. MKONO**

Kichwa cha habari hapo juu cha husika.

2. Ofisi ya Mkurugenzi Mtendaji Halmashauri ya Wilaya Bagamoyo inakiri kupokea barua yako yenye na Kumb Na. **DA.201/457/VOL/1/20** ya tarehe **16 Aprili, 2026** yenye somo tajwa hapo juu.

3. Kwa barua hii, napenda kukufahamisha kuwa mtajwa hapo juu ameruhusiwa kufanya utafiti katika Halmashauri ya Wilaya ya Bagamoyo katika **Idara ya Afya, Ustawi wa Jamii na Huduma za Lishe** katika mada **"An Assessment On Effective Medical Records Management For Improving Service Delivery In Public Hospitals A Case Study Of Bagamoyo District Hospital"** kwa kipindi cha kuanzia tarehe **24 Aprili, 2026** hadi tarehe **08 Mei, 2026.**

4. Namtakia Utafiti mwema.

Shauri Selenda
MKURUGENZI MTENDAJI
HALMASHAURI YA WILAYA
BAGAMOYO

MKURUGENZI MTENDAJI
HALMASHAURI YA WILAYA
BAGAMOYO
S.L.P. 59
BAGAMOYO

Nakala: Mkuu wa Idara,
Idara ya Afya, Ustawi wa Jamii na Huduma za Lishe,
Halmashauri ya Wilaya,
S.L.P. 59,
BAGAMOYO.

Agustine J. Mkono - Ripoti Kwa Mkuu wa Idara ya Afya.

@/WWL/UTAWALA Barua zote zinatakiwa kwa Mkurugenzi Mtendaji (W)
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