SCHOOL OF LIBRARY, ARCHIVES AND DOCUMENTATION STUDIES (SLADS) - BAGAMOYO

A RESEARCH PROPOSAL ON:

AN ASSESSMENT OF ADMINISTRATIVE RECORDS MANAGEMENT PRACTICES IN ENHANCING HEALTH CARE SERVICE DELIVERY: A CASE STUDY AT MKURANGA HOSPITAL.

BY

HENRY.A. JOSEPH

A Research Proposal Submitted to the School of Library, Archives and Documentation Studies Seeking Approval to Undertake a Research Ss a Partial Fulfillment for the Award of Ordinary Diploma in Records and Archive management.

2026

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CERTIFICATION

The undersigned certify that he has read and hereby recommended for acceptance by the School of Library, Archives and Documentation Studies Research report entitled **'An assessment of administrative records management practices in enhancing health care service delivery; a case study at Mkuranga hospital'** as a partial fulfillment of the requirements for the award of Ordinary Diploma in Records and Archives management studies.

Supervisors

ZAINA AMIRI OMARI

Signature

……

Date

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I, **Henry Joseph**, declare that this report is my own original work and that it has not been presented and not be presented to any other Ordinary Diploma or any other award.

Signature……

Date……

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May all Almighty GOD Bless them all.

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DEDICATION

I dedicate this research work to my beloved parents, family members, friends and everyone who provided encouragement, and relatives who gave me financial and psychologist support. Their prayers, guidance, moral support, and continuous motivation greatly contributed to the successful completion of this study.

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LIST OF ABBREVIATIONS AND ACRONYMS

ISO International Standard Organization

WHO World Health Organization

EHRs Electronic Health Records

RAM Record and Archives management

ICT Information Communication Technology

SPSS Statistical Product and Services Solution

SLADS School of Library And Documentation Studies

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ABSTRACT

This study assessed of the administrative records management practices in enhancing health care service delivery at Mkuranga Hospital. The study was conducted to examine the existing administrative records management practices, determine the extent to which the hospital adhered to legal and regulatory frameworks in managing administrative records, identify the challenges affecting effective administrative records management to enhance health care service delivery. The study employed a mixed research approach, which combined both quantitative and qualitative methods. A sample of 25 respondents was selected from administrative staff, record officers, nursing officer, health officer, health information officers, medical registrars, medical doctors, medical in-charge, and records medical clerks. Data were collected using questionaries, interviews. Quantitative data were analyzed using frequencies and percentages and presented in tables, while qualitative data were analyzed using thematic analysis and presented in narrative form. The study found that the hospital faced several challenges, including Inadequate Storage Facilities, Lack of Modern Technology and Insufficient Staff Training. These challenges affected records accessibility, delayed retrieval of information, and reduced the efficiency of health care service delivery.

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CHAPTER ONE

1.0 Introduction

This chapter presented the background to the study, statement of the problem, general objective, Specific objectives, and research questions, significance of the study, the scope of the study, limitation of the study, and the definitions of the key terms.

1.1 Background of the study

Administrative records management has became a critical component in modern healthcare systems worldwide, serving as the backbone for quality service delivery, patient safety, and organizational efficiency. Healthcare institutions generated vast amounts of administrative records daily, including patient files, medical histories, treatment plans, financial documents, and personnel records (World Health Organization, 2019). Effective management of these records ensured continuity of care, supported evidence-based decision-making, and facilitated compliance with legal and regulatory requirements (Ngoepe&Ngulube, 2016). In developed countries, the integration of electronic health records (EHRs) and sophisticated records management systems has revolutionized healthcare delivery by improving accessibility, reducing medical errors, and enhancing coordination among healthcare providers (Kruse et al., 2016).

The transition from paper-based to digital records management systems was accelerated globally, particularly in high-income countries where technological infrastructure supported seamless information exchange (Ahmadi et al., 2017). Studies conducted in the United States, the United Kingdom, and Australia demonstrated that well-managed administrative records contributed significantly to improved patient outcomes, reduced healthcare costs, and enhanced operational efficiency (Menachemi&Collum, 2011; Sheikh et al., 2011). The International Organization for Standardization (ISO) established standards such as ISO 15489 for records management emphasized the need for systematic approaches to creating, capturing, and managing records in healthcare settings (ISO, 2016). However, despite these advancements, many healthcare institutions globally

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continued to face challenges related to inadequate storage facilities, lack of trained personnel, and insufficient policies governing records management practices (Asogwa, 2012).

Furthermore, the COVID-19 pandemic highlighted the critical importance of robust administrative records management systems in healthcare delivery, as institutions worldwide struggled to manage increased patient volumes and coordinate care effectively (Bokolo, 2021). The pandemic accelerated digital transformation initiatives and underscored the need for resilient records management infrastructure capable of supporting remote access, data sharing, and real-time information exchange (Ting et al., 2020). International health organizations emphasized that poor records management practices led to fragmented care, increased medical errors, legal liabilities, and compromised patient safety (WHO, 2021).

Administrative records management in healthcare faced unique challenges stemming from limited resources, inadequate infrastructure, and insufficient technical capacity (Katuu, 2015). Many African countries continued to rely heavily on paper-based records systems, which were vulnerable to damage, loss, and deterioration due to environmental factors and inadequate storage facilities (Kemoni, 2007). Studies conducted across various African nations revealed that healthcare institutions struggled with record accessibility, retrieval inefficiencies, and incomplete documentation, which negatively affected service delivery (Lwanga, 2011). The African Health Observatory reported that poor records management contributed to difficulties in disease surveillance, health planning, and resource allocation across the continent (AHO, 2018).

Countries such as South Africa, Kenya, and Nigeria have initiated reforms to modernize their healthcare records management systems, recognizing the link between efficient record-keeping and quality healthcare delivery (Marutha, 2016). However, implementation challenges persisted, including financial constraints, resistance to change, inadequate training programs, and lack of standardized protocols (Ngoepe, 2017). Research conducted in East African countries demonstrated that healthcare workers often lacked proper training in records management principles, leading to inconsistent

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documentation practices and information gaps (Mnjama, 2013). Additionally, the absence of comprehensive legal frameworks and enforcement mechanisms for records management in many African countries further exacerbated the problem (Ngoepe&Keakopa, 2011).

The African Union's Agenda 2063 emphasized the importance of digital transformation and information management in achieving sustainable development goals, including improved healthcare delivery (African Union, 2015). Several African countries have embarked on Health initiatives aimed at digitizing health records and improving data management capabilities (Mars & Scott, 2017). Nevertheless, the digital divide, characterized by limited internet connectivity, unstable power supply, and high technology costs, continued to hinder progress in implementing modern records management systems across the continent (Moodley et al., 2020).The Tanzania healthcare system served a population of over 60 million people through a network of public and private health facilities, ranging from dispensaries to referral hospitals (Ministry of Health, Community Development, Gender, Elderly and Children [MoHCDGEC], 2020). Administrative records management in Tanzanian healthcare institutions faced significant challenges that impeded effective service delivery and patient care outcomes (Malangalila et al., 2019). The majority of health facilities in Tanzania continued to use manual paper-based records systems were characterized by poor organization, inadequate storage spaces, and vulnerability to environmental damage (Nyamtema et al., 2016).

The Tanzanian government has recognized the importance of strengthening health information systems, as evidenced by the Health Sector Strategic Plan V (2021-2026), which prioritized improving data management and records keeping practices (MoHCDGEC, 2021). Despite these policy commitments, implementation remained weak due to resource constraints, limited technical expertise, and insufficient investment in records management infrastructure (Lungo, 2008). Studies conducted in Tanzanian hospitals revealed that healthcare providers frequently encountered difficulties in retrieving patient records, leading to repeated diagnostic tests, treatment delays, and compromised patient safety (Mtega et al., 2016).

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Furthermore, the lack of standardized procedures for creating, maintaining, and disposing of administrative records contributed to inconsistencies across health facilities (Semali&Mkumbo, 2018). Research by Lyimo and Mushi (2019) found that inadequate supervision, limited training opportunities, and absence of clear accountability mechanisms resulted in poor records management practices in Tanzanian healthcare settings. The introduction of District Health Information System 2 (DHIS2) represented an attempt to modernize health data management in Tanzania, but challenges related to user competency, system integration, and sustainability persisted (Manya et al., 2020). Understanding the current state of administrative records management practices in Tanzania was essential for developing targeted interventions that could enhance healthcare service delivery and improve patient outcomes.

1.2 Statement of the problem.

Administrative records management in healthcare institutions should have been characterized by systematic processes for creating, maintaining, storing, retrieving, and disposing of records in accordance with established standards and best practices (ISO, 2016). Healthcare facilities should have maintained complete, accurate, and up-to-date patient and administrative records that were easily accessible to authorized personnel whenever (WHO, 2019). Effective records management systems should have supported clinical decision-making, facilitated continuity of care, ensured regulatory compliance, and enabled evidence-based health planning and policy development (Ngoepe&Ngulube, 2016). Furthermore, healthcare institutions should have had adequate infrastructure, trained personnel, clear policies, and technological support to manage records efficiently throughout their lifecycle (Marutha, 2016).

However, the situation in most of Tanzanian healthcare institutions revealed a stark contrast to this ideal. Administrative records management practices were characterized by disorganized filing systems, inadequate storage facilities, missing or incomplete records, and lengthy retrieval times (Malangalila et al., 2019). Healthcare facilities lacked sufficient trained records management personnel, resulting in improper handling and

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maintenance of critical documents (Semali&Mkumbo, 2018). Many institutions continued to rely on outdated paper-based systems without clear retention schedules or disposal procedures, leading to accumulation of obsolete records and overcrowded storage spaces (Mtega et al., 2016). Additionally, the absence of comprehensive policies, weak supervision, and limited resources further compromised the quality of records management practices (Lyimo& Mushi, 2019). These deficiencies in administrative records management had serious consequences for healthcare service delivery in Tanzania. Poor record-keeping practices led to fragmented patient care, because healthcare providers could not access complete medical histories necessary for informed decision-making (Nyamtema et al., 2016). This resulted in repeated diagnostic procedures, inappropriate treatments, increased medical errors, and compromised patient safety (Lungo, 2008). From an administrative perspective, inadequate records management hampered effective planning, resource allocation, monitoring, and evaluation of health programmes (MoHCDGEC, 2020). The inability to retrieve accurate data undermined evidence-based policy development and accountability mechanisms (Manya et al., 2020). Furthermore, poor records management exposed healthcare institutions to legal liabilities, financial losses, and erosion of public trust in the healthcare system (Marutha, 2016) which resulted in poor health care service delivery. Therefore, there was an urgent need to assess administrative records management practices in enhancing health care service delivery at Mkuranga Hospital.

1.3 Objective of the study

This section provides information about the general and specific objectives that guide the present study.

1.3.1 General objectives

To assess administrative records management practices in enhancing health care service delivery in Mkuranga Hospital.

1.3.2 Specific objectives

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i. Assess the existing practices for managing administrative records at Mkuranga Hospital.
ii. To examine to which extent Mkuranga Hospital adhering to the available legal and regulatory framework in managing administrative records.
iii. To identify the challenges hindering effective Administrative Records Management practices at Mkuranga Hospital.

1.4 Research questions

i. What are the existing records management practices for managing Administrative Records at Mkuranga Hospital?
ii. To what extent does Mkuranga Hospital adhere to the available legal and regulatory framework for managing administrative records?
iii. What challenges does Mkuranga Hospital face in managing administrative records?

1.5 Significance of the study

This study held significant value for multiple stakeholders in the Tanzanian healthcare sector. For policymakers and government officials, the findings will provided evidence-based insights to inform the development of comprehensive records management policies, standards, and guidelines for healthcare institutions. Healthcare administrators and managers benefited from understanding the relationship between effective records management and healthcare service delivery quality, enabling them to prioritize investments in infrastructure, training, and systems improvement.

Additionally, the study's recommendations guided development partners and donor organizations in designing targeted interventions and resource allocation strategies to strengthen health information systems in Tanzania. Patients and the general public benefited from improved healthcare service delivery resulting from enhanced records management practices, including reduced waiting times, fewer medical errors, and better continuity of care. Finally, the research contributed to the achievement of sustainable

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development goal 3 which aims to ensure healthy lives and promote well-being for all, as well as supporting the implementation of national health sector strategic objectives at Mkuranga Hospital.

1.6 Scope and Limitations of the Study

This section provided information describing the coverage of the study and potential limitations that researcher faced during the study.

1.6.1 Scope of the study

This study focused specifically on administrative records management practices at Mkuranga Hospital and their impact on healthcare service delivery. The research encompassed the examination of medical files, administrative documentation, and health information systems utilized within the hospital setting. The scope included the analysis of the creation, maintenance, storage, retrieval, and disposal of administrative records in accordance with Tanzanian health records management policies and international best practices. This study focused specifically on administrative records management practices at Mkuranga Hospital and their impact on healthcare service delivery. The research encompassed the examination of patient records, medical files, administrative documentation, and health information systems utilized within the hospital setting.

1.6.2 Limitation of the study,

The study examined both paper-based and electronic records management systems currently operational at the district hospital, considering the hybrid nature of healthcare documentation in many developing countries. Time constraints limited the period of data collection and observation periods, potentially missing seasonal variations or periodic changes in records management practices that occur throughout the year, Financial limitations restrict the scope of technological assessments and prevented a comprehensive evaluation of potential digital health record systems that could be implemented, likewise, language barriers may present challenges as some administrative records and

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documentation may be in English while staff and patients primarily communicate in Kiswahili, potentially affecting data interpretation Respondent bias represents a significant limitation.

1.7 Definition of Key Terms

This section presented operational definitions of various key terms and concepts that were applied in this study.

1.7.1 Records

Are documented information or data, regardless of format or medium, created, received, and maintained as evidence and information by an organization or person in pursuance of legal obligations or in the transaction of business (ISO 15489-1:2016).

1.7.2 Records Management

Is the field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use, and disposition of records, including processes for capturing and maintaining evidence of and information about business activities and transactions (ISO 15489-1:2016).

1.7.3 Records Management Practices

Refer to the systematic procedures, methods, and activities employed to control records throughout their lifecycle, from creation or receipt through processing, distribution, organization, retrieval, and final disposition (Katuu, 2016).

1.7.4 Administrative Records

Are documents created, received, and maintained in the course of administrative operations and management activities of an organization, including correspondence, reports, policies, procedures, budgets, personnel files, and other documents that support organizational governance and decision-making (Zawiyah &Chell, 2015).

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1.7.5 Legal Framework

In records management encompasses the laws, regulations, standards, policies, and guidelines that govern the creation, maintenance, protection, access, retention, and disposal of records within a specific jurisdiction or sector (Kemoni, 2017).

1.7.6 Health Records

Health records, also known as medical records or patient records, are systematic documentation of a patient's medical history, clinical findings, diagnostic test results, treatment plans, and healthcare services provided, maintained in either paper or electronic format for continuity of care, legal protection, and quality assurance (WHO, 2016).

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

According to Kothari (2014), a literature review can be defined as the process of identifying or locating, reading, evaluating, summarizing and incorporating in the study documents involving materials that are related to the problem under investigation. This chapter covers the literature review part of the study where their theoretical and empirical literature review which includes a figure of records life cycle, review of previous studies related to the study and also consists the research gap.

2.1 Overview of Health Records Management

Administrative records were vital documents that supported the daily operations of healthcare facilities. According to Mutsagondo and Chaterera (2020), proper management of administrative records ensured that patient information, staff records, and operational documents were easily accessible whenever they were needed. In healthcare settings, administrative records included patient files, appointment schedules, billing information, personnel records, and procurement documents. The effective management of these records contributed directly to quality healthcare delivery and operational efficiency. Ngoepe and Ngulube (2016) observed that many healthcare institutions still relied on manual filing systems, which often led to misplacement and loss of important documents. Their study in South African public hospitals revealed that records were frequently stored in overcrowded filing cabinets without proper indexing or classification systems. This situation made it difficult for healthcare workers to retrieve records quickly, especially during emergency situations. Similarly, Kemoni (2017) found that inadequate storage facilities and poor record-keeping practices in Kenyan hospitals resulted in delayed service delivery and compromised patient care. The transition from paper-based to electronic records management systems had been gradual in many developing countries. Katuu (2018) noted that electronic health records systems offered significant advantages,

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including faster retrieval of information, reduced physical storage space, and better security of sensitive data. However, the implementation of electronic systems required substantial financial investment, technical infrastructure, and staff training. In Tanzania, studies by Msiska and Mvungi (2019) indicated that most district hospitals still maintained paper-based records due to limited resources and inadequate technical capacity. Record classification and indexing were fundamental practices in administrative records management. Wamukoya and Mutula (2015) emphasized that proper classification systems enabled healthcare workers to organize records systematically and retrieve them efficiently. Their study revealed that healthcare facilities that implemented standardized classification schemes, such as alphabetical or numerical filing systems, experienced fewer incidents of lost records. Furthermore, Asogwa (2019) highlighted that regular auditing of records helped identify gaps in record-keeping practices and ensured compliance with established procedures. The role of records management staff was critical in maintaining effective administrative records systems. Mnjama and Wamukoya (2020) pointed out that healthcare institutions needed trained records officers who understood the principles of records management and could implement best practices. Unfortunately, many hospitals assigned record-keeping duties to untrained administrative staff, which resulted in poor record organization and management. Training program meson records management procedures, filing systems, and archival practices were essential for improving the quality of records management in healthcare settings. Security and confidentiality of administrative records are paramount concerns in healthcare facilities. According to Tough and Lund (2018), patient records contained sensitive personal and medical information that had to be protected from unauthorized access. Healthcare institutions implemented access control measures, such as restricted entry to records storage areas and password-protected electronic systems. Failure to maintain confidentiality can led to legal consequences and loss of patient trust. Mosweu and Mosweu (2021) noted that inadequate security measures in African hospitals had resulted in incidents of record theft and unauthorized disclosure of patient information. Retention and disposal of records were important aspects of records management that ensured

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compliance with legal requirements and efficient use of storage space. Ngoepe (2017) argued that healthcare institutions had to develop retention schedules that specified how long different types of records should be kept before disposal. Medical records, for instance, needed to be retained for several years after a patient's last visit, while financial records had different retention periods. Proper disposal procedures, such as shredding confidential documents, prevented unauthorized access to discarded records.

2.2 Legal and Regulatory Framework in Managing Health Record Management

Legal and regulatory frameworks provided the foundation for effective records management in healthcare institutions. According to Bwalya and Zulu (2018), laws and regulations established standards for creating, maintaining, and disposing of records, thereby ensuring accountability and transparency in public institutions. In Tanzania, the Records and Archives Management Act No. 3 of 2002 governed the management of public records, including those in healthcare facilities. This legislation mandated that all government institutions maintained proper records and submitted non-current records to the National Archives for preservation. The Health Information Management policy provided specific guidelines for managing health records in Tanzania. Mosha (2019) explained that this policy outlined the responsibilities of healthcare providers in maintaining accurate and complete patient records. It also addressed issues of confidentiality, security, and patient rights to access their medical records. Compliance with this policy was essential for healthcare institutions to provide quality services and protect patient information. However, Makulilo (2016) observed that many healthcare facilities in Tanzania were not fully aware of these legal requirements or lacked the capacity to implement them effectively. International standards, such as the ISO 15489 standard for records management, provided best practice guidelines that can be adopted by healthcare institutions. Katuu and Ngoepe (2015), noted that this standard emphasized the importance of systematic control of records throughout their lifecycle, from creation to disposal. Healthcare facilities that aligned their practices with international standards benefited from improved efficiency, reduced legal risks, and enhanced service delivery. However, implementing these standards required commitment from management and

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adequate resources. Data protection laws became increasingly important in the digital age, as healthcare institutions stored more information electronically. According to Makulilo and Haule (2020), the Tanzania Data Protection Act of 2022 regulated the processing of personal data and imposed obligations on organizations to protect sensitive information. Healthcare facilities were required ensure that patient data is collected, stored, and shared in compliance with this law. Non-compliance can result in legal penalties and damage to the institution's reputation. The law also grants patients the right to access their records and request corrections to inaccurate information. Regulatory bodies, such as the Records and Archives Management Department and health regulatory authorities, played a crucial role in enforcing compliance with records management laws. Keakopa (2015), emphasized that these institutions conducted inspections and audits to ensure that healthcare facilities maintained proper records. They also provide guidance and training to records management staff. However, Kemon and Ngulube (2019), found that limited resources and staffing constraints often hinder regulatory bodies from effectively monitoring compliance in all healthcare institutions.The legal framework also addresses the challenges of record preservation and long-term access. According to Lowry (2017), archival legislation ensures that historically valuable records are preserved for future generations. In healthcare, certain records may have long-term research or legal value and should be transferred to archival repositories. However, many healthcare facilities lack clear procedures for identifying and transferring such records. Ngoepe and Keakopa (2016), suggested that stronger collaboration between healthcare institutions and national archives is needed to ensure proper preservation of valuable records. Despite the existence of legal frameworks, enforcement remains a challenge in many developing countries. Mnjama (2018), observed that healthcare institutions often operate without adequate oversight, leading to poor records management practices. Penalties for non-compliance are rarely enforced, which reduces the incentive for institutions to improve their practices. Strengthening enforcement mechanisms and increasing awareness of legal requirements among healthcare administrators are essential steps toward better records management.

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2.3 Challenges facing health records management

Healthcare institutions face numerous challenges in managing administrative records effectively. One of the most significant challenges is inadequate infrastructure for records storage. According to Chaterera (2021), many healthcare facilities lack proper storage facilities, resulting in records being kept in unsuitable environments that expose them to deterioration, pests, and fire hazards. In some cases, records are stored in corridors or unused rooms without proper shelving or climate control. This situation not only threatens the physical integrity of records but also makes retrieval difficult and time-consuming. Limited financial resources pose another major obstacle to effective records management. Ngoepe and Saurombe (2016), found that budget constraints prevent healthcare institutions from investing in modern filing equipment, electronic records systems, and adequate storage facilities. Records management is often regarded as a low priority compared to clinical services, resulting in minimal allocation of funds for this function. Consequently, healthcare facilities continue to operate with outdated and inefficient records management systems that compromise service delivery.

The shortage of trained records management personnel is a critical challenge in many healthcare institutions. Mosweu (2020), noted that most healthcare facilities do not have dedicated records officers, and record-keeping responsibilities are assigned to general administrative staff who lack specialized training. This leads to inconsistent application of records management principles, poor organization of files, and increased risk of record loss. Management commitment to records management is often lacking, which undermines efforts to improve practices and allocate necessary resources. Security threats, including theft, unauthorized access, and loss of records, are ongoing concerns in healthcare facilities. Mutula and Wamukoya (2016), highlighted that weak security measures allow unauthorized individuals to access sensitive patient information. Physical security measures, such as locked filing cabinets and restricted access to records rooms, are often inadequate or poorly enforced. In electronic systems, cyber security risks, including hacking and data breaches, pose serious threats to the confidentiality and

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integrity of records. The accumulation of non-current records creates space constraints and hampers efficient records management. Tough (2019), explained that many healthcare facilities fail to implement proper records disposal procedures, resulting in the retention of records beyond their required retention periods. This leads to overcrowded storage areas and difficulty in locating current records. Establishing and enforcing retention schedules, along with secure disposal methods for obsolete records, is essential for managing storage space effectively. Lack of standardized records management procedures and policies is another significant challenge. According to Keakopa (2017), the absence of clear guidelines on how records should be created, classified, stored, and disposed of results in inconsistent practices across different departments within the same institution. This inconsistency complicates record retrieval and sharing of information between departments. Developing comprehensive records management policies and ensuring their implementation across all units of the healthcare facility is crucial for improving records management practices.

2.4 Theoretical framework

The theoretical framework for this study provides a lens for examining how administrative records management influence healthcare service delivery (Katuu, 2016; Shepherd& Yeo, 2015). In institutions such as Mkuranga Hospital, proper management of records ensures that information is accurate, timely, and accessible, supporting patient care, clinical decision making and accountability. The framework thus established the theoretical basis for linking records management practices to the quality of healthcare services.

2.4.1 The Records Life Cycle Model

The Records Life Cycle Model has been one of the most influential models in records management, especially in North America since the 1960s. The concept was strongly articulated by Schellenberg, who explained that records have a life span similar to that of a living organism (Katuu, 2016). According to (Nyamtema, 2016), recorded information is “born” during the creation phase, “lives” during maintenance and use, and eventually

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"dies" at the disposition stage. Shepherd and Yeo (2015) describe these three stages as the current stage, semi-current stage, and non-current stage. During the current stage, records are actively used for business activities and decision-making. At this phase, records are created either internally or received from external sources such as reports, forms, letters, and directives (Katuu, 2016). Records at this stage are normally kept in the creating office and frequently consulted. However, caution that records should only be created, when necessary, because unnecessary creation leads to accumulation and inefficiency. In the context of Mkuranga Hospital, this stage includes the creation of patient registration and admission records, medical history documentation and clinical notes, Diagnostic test results and imaging reports, Treatment plans and prescription records, administrative correspondence and forms, Proper management at this stage is important because these records form the foundation of transparency and accountability.

The semi-current stage occurs when records are no longer used frequently in daily operations but still have administrative, legal, or financial value. At this stage, records are usually transferred to a records Centre for storage. (Katuu, 2016), explains that many semi-current records must be retained for specific legal or regulatory periods. Their maintenance should be guided by retention schedules and supported by proper classification, indexing, and tracking systems. In Mkuranga Hospital, semi-current health records may still be required for Regularly accessed by healthcare professionals for patient care, updated with new clinical information and treatment outcomes, shared among authorized personnel for continuity of care, used for billing, insurance claims, and administrative purposes, Referenced for quality assurance and clinical decision-making. The non-current stage refers to records that are no longer required for active business use. At this stage, a review process is conducted to determine which records should be destroyed and which should be preserved permanently in archives Asogwa (2019), Only a small percentage of records are usually preserved for long-term historical or legal value. The decision to preserve or destroy records is guided by retention and disposition schedules (Ngoepe and Ngulube 2016), explain that records appraisal involves evaluating

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records based on administrative, legal, fiscal, and historical value. In this stage, archivists are responsible for preserving, describing, and providing access to archival records.

Figure 2. 1: The records life cycle



Source: Roper and Millar (1999b: 19)

The life cycle model clearly defines responsibilities between records managers and archivists. Records managers are responsible during the current and semi-current stages, while archivists take responsibility during the non-current stage. This clear separation makes the model simple and practical to apply in organizations. For institutions like Mkuranga Hospital, regularly accessed by healthcare professionals for patient care, updated with new clinical information and treatment outcomes, shared among authorized personnel for continuity of care, used for billing, insurance claims, and administrative purposes, Referenced for quality assurance and clinical decision-making. Where many records are still paper-based, the life cycle model provides auseful framework for assessing how records are managed from creation to final disposition and how this management supports transparency.

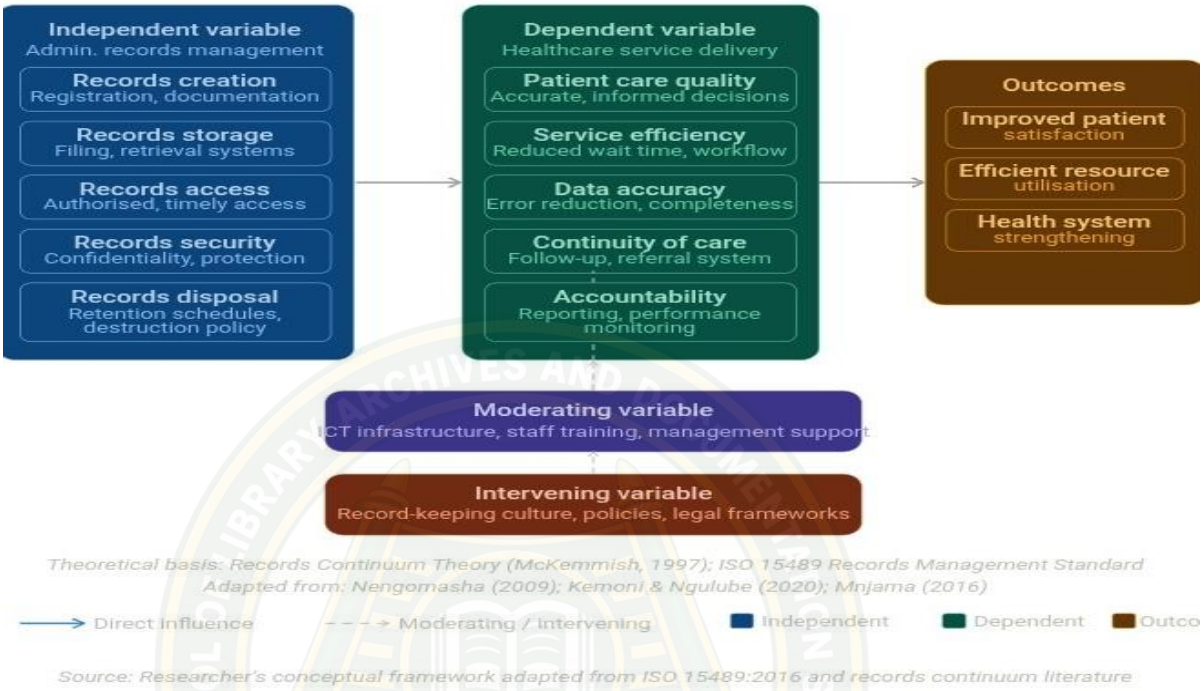
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2.5 Conceptual framework

A conceptual framework is a structured way of explaining the main concepts, variables, and relationships involved in a research study. It helps researchers show how different ideas or variables are connected and guides the direction of the study. According to Uma Sekaran and Roger Bougie (2016), a conceptual framework is; a model that shows the relationship among the variables in a study and explains the theoretical basis of these relationships. Administrative records management practices involve the systematic control of records throughout their life cycle, including creation, classification, storage retrieval, and disposal, Read & Ginn (2011). Administrative records management (the independent variable); including records creation, storage, access, security, and disposal-directly influences healthcare service delivery (the dependent variable) in terms of patient care quality, efficiency, data accuracy, continuity of care, and accountability. The relationship between these two variables is moderated by factors such as ICT infrastructure, staff training, and management support. It is also influenced by intervening variables including records keeping culture, organizational policies, and legal frameworks. When these variables are well managed, the expected outcomes are improved patient satisfaction, efficient resource use and stronger health system.

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Figure 2.2: Conceptual Frame work



Source: Researcher's conceptual framework adapted from ISO 15489:2016 and records continuum literature

The conceptual framework for this study is based on the understanding that effective records management is central to efficient healthcare service delivery. Records management involves the systematic control of records from creation or receipt to their eventual preservation or destruction (ISO, 2016), while the Records Continuum Theory highlights those records, such as patient files, are living documents guiding current and future care (McKemmish, 1997). Administrative health records including patient registration forms, attendance logs, stock and financial records, and staff schedules support the smooth operation of health facilities (WHO, 2019), and poor management of these records can lead to inefficiencies, long patient waiting times, and staff frustration (Chiyemba&Ngulube, 2015). Studies have shown that structured records management improves service delivery by reducing errors, duplication, and patient complaints (Kemoni&Ngulube, 2002; Mnjama, 2016). The adoption of Electronic Health Records (EHR) further enhances efficiency by speeding up record retrieval and minimizing clinical errors, although challenges in infrastructure and staff training remain (Abdi, Rahimi & Ahmadi, 2015; Kalusopa&Ngulube, 2016). The framework is also shaped by policy and

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legal provisions, which emphasize standardized records management practices, though inconsistent implementation and limited staff awareness often hinder compliance (ISO, 2016; Ngoepe&Ngulube, 2015). Collectively, this framework underscores the critical link between systematic records management, administrative efficiency, and the quality of healthcare service delivery.

2.6 Research Gap

Administrative records management in various sectors, several gaps remain in the literature, particularly concerning healthcare institutions in Tanzania. Most existing studies focus on general records management practices in public institutions without specifically examining the unique challenges faced by healthcare facilities. Asogwa (2020). The healthcare sector has distinct requirements due to the sensitive nature of patient information, the need for rapid access to records during emergencies, and strict confidentiality requirements. Previous studies have primarily concentrated on urban and regional hospitals, with limited attention given to district-level healthcare facilities. District hospitals serve large populations and face resource constraints that differ from those of larger institutions. Ngoepe and Keakopa (2016) Understanding the specific challenges and practices at the district level is essential for developing targeted interventions that can improve records management across the entire healthcare system. There is insufficient empirical evidence on how administrative records management practices at district hospitals impact service delivery outcomes. This study seeks to address these gaps by conducting a comprehensive assessment of administrative records management practices in district healthcare facilities, examining the implementation of legal and regulatory frameworks, and identifying specific challenges that hinder effective records management. The findings will contribute to the body of knowledge on healthcare records management in Mkuranga District Hospital and provide practical recommendations for improving practices at district levels hospitals in Tanzania.

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CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter explained various aspects that was applied in carrying out the research study, it described the research design, research approach, target population, area of the study, sample size, sampling technique, validity and reliability, and ethical considerations were also included.

3.1 Research Approach

A research approach was a plan of action that provided direction to conduct research systematically and efficiently (Daniel, 2016). The research methodology comprised three research approaches according to Neuman (2003) which are qualitative, quantitative and mixed. The researcher used a mixed approach where both qualitative and quantitative methods will use to collect and analyze data. In this study, these approaches will help the researcher to obtain more details and specific information about the problem of the study. It also gave freedom to the researcher to use narration and numbers during data analysis. Creswell and Plano (2006) support the researcher to use mixed approach as it allows the collection of a wider range of data for a deeper and clear understanding of the problem.

3.2 Research Design

According to Bell, Bryman, & Harley (2019) research design was a framework for the collection and analysis of data. The most important decision in research design is the choices to be made concerning the research approach since it helps to determine how a particular study will be. The researcher will employ a Case Study design. In this study, the researcher decided to use Single Case Study Design; this is a kind of Case Study Design where the study investigates the Single Case to get in-depth information (Matthew and Liz, 2015). This design enables a researcher to study a single institution indeed to get

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detailed information in such case (institution). The researcher used this design because wanted to study a single institution.

3.3 Area of the study

Ngechu (2006) defines an area of study as the limit of the study or problem. The study will be conducted at Mkuranga Hospital located in Pwani region. It is one of Hospital in Pwani region. The selection of this Mkuranga Hospital is because there are few numbers of related studies that have been conducted in the area as well as familiarity of the researcher with the study environment also researcher choose the study area because this is among of Hospital that possess health records.

3.4 Target population

According to Cresswell (2012), a population is defined as a group of individuals who have similar features that help them to be different from other groups, likewise, population is the entire group we are interested in and wish to describe or draw a conclusion. (Kombo&Tromp, 2006). In this study, the researcher will use a population of 25 respondents at Mkuranga Hospital.

3.5 Sample size and sampling procedure

This section describes the sample and sampling procedures used in the study.

3.5.1 Sample size

A sample is one that can be taken as representative of the whole population where by its results can be generalized (Kothari, 2004). Also sample size is a number of sampling units were included in a sample (Saman, 2003**).** A total of respondent twenty-five (25) will be selected to participation in this study. Whereby twenty (20) respondents will be responsible in filling questionnaire who are staff from administrative staffs and management staff (Records officers 4, nursing officer 8, health information officers 2,

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administrative staff 2 and medical registration 2) at Mkuranga hospital and other five (5) respondents will be interviewed like senior human resource 1, records medical clerks 2, medical in-charge 1, medical doctors 1.

The sample size of this study will be obtained by using the formula introduced by Taro Yamane (1964) as cited by Johnson (2011). Which stated that; n=N/(1+N(e)2)

Whereby;

n= sample size

N= number of populations = 25

e= number of acceptable errors= 0.1

n= 25/ $(1+25(0.01)^2$

n= 25/1+1.5

n= 25.

3.5.2 Sampling Procedures

Sampling techniques are methods where researcher uses to select a population's representatives that can be used to make inferences or generalization on the whole population concerning an existing theory (Taherdoost, 2018). In this study, both probability and non-probability sampling techniques will be used to select the sample required by the study. The probability sampling technique that will be used in the study will be random sampling technique. This technique will be used to select record administrative officers to fill questionnaires. On the other hand, a non-probability technique called purposively or judgmental sampling will used to obtain key informant who is clinical officers that will be included in interviews.

3.5.2.1 Simple Random Sampling Technique

Simple random sampling refers to the kind of probability sampling which requires that each member of the population to have an equal chance of being selected or included as a sample (Verma, et al, 2017). In this study simple random sampling will be used so as to

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eliminate bias by giving all people in a field area an equal chance to be selected in the study.

3.5.2.2 Purposive Sampling Techniques

According to Glenton&Lewin, (2019) Purposive Sampling is a method that belongs to the category of non-probability sampling techniques that permits a researcher to select samples on the bases of their knowledge, relationships and expertise in relation to the objective of the study. In this study, this method will be used to get key information which cannot be attained from other techniques where twenty-five (25) respondents (Hospital administrate/medical in charge, record officers/medical records clerks, district health officer, health information officers) from a sample size.

3.6 Data Collection Method

Data collection is the process of gathering and measuring information on the variable of interest in an established systematic style that enables one to answer stated research questions (Kabir, 2016). In this study, the researcher will use two major sources of data collection which include primary and secondary sources since the combination of these methods improves validity and reliability. The researcher will distribute questionnaires to Hospital staff. The questionnaires will contain both closed ended questions and open-ended questions. The questions will focus on areas such as; how records are created, how records stored, how records are retrieved, how records are protected and secured, how records help in decision making.

3.6.1 Secondary Data

Secondary data refers to data that is collected by someone other than the user (Raj, 2005). Secondary data will be collected by reviewing documents related to the study. Relevant publish and unpublish materials were examined and used for the study objectives. In order to facilitate the collection of accurate and trustworthy data base on the study objectives, a review of patient and helpful resources was conducted. Secondary data in this study will

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be collected through reviewing research reports of other scholars' theses and dissertations, books, journals and articles (secondary sources) related to the study.

3.6.2 Primary data

Primary data refers to the data from sources that the researcher directly collects through interviews, observation and questionnaires. Glenton&Lewin, (2019). Primary data are those which are collected with a fresh hand for the first time, and thus happen to be original. Primary data will be collected from the sample population by using questionnaire methods.

3.6.2.1Questionnaire Method

According to Kabir (2016) questionnaire is a research tool which includes a series of written and printed questions that are in a systematic order to gather information from the respondents. Then allowing them to attempt the questions individually and yield the filled queries to the researcher. In this study, the researcher will apply both close-ended and open-ended questions, whereas open-ended questions provide freedom to respondents to provide more details while close-ended questions usually do not provide freedom to the respondents for more explanation (Creswell2012). This study will apply questionnaire method to Mkuranga Hospital staff, since it helps to eliminate bias to the respondents. Therefore, twenty (20) respondents will be responsible to fill questionnaire that are staff from Mkuranga hospital such as (Records officers 4, nursing officer 8, health officers 2, health information officers 2, administrative staff 2 and medical registrators 2)

3.6.2.2 Interview Method

Interview is one of the instruments of data collection that involves one to one meeting at which one is asked the target questions related to the research problem (Rwagoshora, 2006). This study will use a semi-structured interview to obtain data, whereas a semi-structured interview is a kind of interview that employs a blend of closed-ended questions and open-ended questions. The researcher will use this method to collect key information from five (5) respondents that will be interviewed like senior human resource 1, records

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medical clerks 2, medical in-charge 1, medical doctors 1since it allows rearranging any query accordingly to acquire appropriate information

3.6.2.3 Observation Methods

Observation is a data collection method that involves systematically watching and recording behaviors, activities, or processes as they occur in their natural setting. According to Mark Saunders et al. (2016), observation allows the researcher to obtain first-hand information about actual practices and behaviors within an organization. In this study, observation will be used to examine how digital records are created, stored, organized, and retrieved within Mkuranga Hospital. This method will enable the researcher to directly observe the practical implementation of digital records management practices and how they support service delivery within the Mkuranga Hospital.

3.7 Instrumentation

A according to Creswell and Plano Clark (2007), instrumentation refers to the tools and methods used by the researcher to collect data from respondents. These tools collectively enable the researcher to understand how records are managed and how they influence healthcare service delivery. Because this study used a mixed methods approach, different data collection tools were used to gather information. Mixed methods allow the researcher to use both qualitative and quantitative tools instead of depending on only one type of data collection method.

3.7.1 Questionnaire guide

A questionnaire is a structured tool used to systematically collect information from a large group of respondents. The questionnaire is designed to collect data from hospital staff Chiyemba&Ngulube (2015). It captures both quantitative and qualitative information on administrative records management and its impact on healthcare delivery. Key focus areas include staff demographics, knowledge of records management policies, frequency and methods of record creation and retrieval, challenges faced, and the perceived impact of record-keeping on service delivery ISO 2016). This tool allows efficient collection of data

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from multiple respondents, providing statistical insights into the hospital's record management practices.

3.7.2 Interview guide

An interview guide is a semi-structured tool that facilitates in-depth conversations with key informants to explore their experiences, opinions, and insights. The study will use interview guide to gather detailed information from senior human resource 1, records medical clerks 2, medical in-charge 1, medical doctors 1. The guide explores perceptions of the importance of administrative records, experiences with paper-based and electronic records management, challenges in maintaining and retrieving records, and suggestions for improving practices). Interviews provide qualitative insights that complement the broader data collected through questionnaires.

3.7.3 Observation Checklist

An observation checklist is a structured tool used to systematically assess and verify actual practices and conditions in a given environment. It is applied to directly observe administrative and patient records management at the hospital Kemoni&Ngulube, (2002). The checklist focuses on organization and storage of records, accessibility to authorized staff, record creation and disposal, use of ICT or EHR systems, compliance with policies, and physical conditions affecting record management ISO (2016). This tool enables the researcher to confirm practices and conditions in real time, providing evidence that may not be captured through questionnaires or interviews.

3.8 Data quality control

Data quality control refers to the processes and mechanisms that ensure that the information recorded in health care administrative system is accurate, complete, timely, consistent and reliable. In the context of administrative records management, this essential because health care service delivery heavily relies on correct and accessible operational

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data. Poor data quality control can lead to misdiagnosis, delays in service, resources misallocation, and general inefficiency.

3.8.1 Validity and Reliability

Creswell (2012) is of the view that validity is the development of sound evidence to demonstrate that the test interpretation matches its proposed use. That means validity is about testing the instruments to see whether they measure what is intended to measure thus bringing the intended results. While reliability is about the degree to which a particular measuring procedure gives similar results over several repeated trials, he further adds that if the results are different then the measurement is reliable.

3.9 Data analysis and processing

Krishna (2004) defines data analysis as the means of critical examination of the assembled and grouped data for studying the characteristics of the object under the study and for defining arrangements of association among the variable connecting to it. The researcher will obtain both quantitative and qualitative data, and each has its way of analyzing data. As in quantitative, data can be analyzed by a statistical method by using excel and Statistical Product and Service Solutions (SPSS) but qualitative data will be analyzed by using the content analysis method since qualitative data are in form of the word not numerical.

3.9.1 Pilot study

Is referred to as a pre-study which is defined as a small study, a pilot study carried out to ensure the validity and reliability of the research instruments. A pilot study is typically conducted with a small representative sample identical to but not including the group to be studied. (Orodho, 2010). Further states that the main reason for conducting the pilot study will test the weaknesses and strengths of research instruments to correct their weaknesses and also help the researcher to be familiar with the research instruments.

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3.10 Research Ethics

Research ethics require a researcher to follow appropriate guidelines and rules for protecting participant's dignity as well as publishing relevant and ethical oriented information (Kothari, 2019). To ensure ethical consideration, the researcher introduced the purpose of the research to the respondents, this brought honesty and cooperation to participate in the study. Also, the researcher used the information obtained from the field for academic purposes only while maintaining the confidentiality of the respondents were participated in this study, lastly, the researcher ensured that all relevant sources involved

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CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.0 Introduction.

This chapter presents the analysis and interpretation of data collected from the study and explains what they mean in relation to the research topic, '**An assessment of administrative records management practices in enhancing health care service delivery at Mkuranga Hospital**'. The study guide three objectives, Assess the existing practices for managing administrative records at Mkuranga Hospital, to examine to which extent Mkuranga hospital adhering to the available legal and regulatory framework in managing administrative record, to identify the challenges hindering effective administrative records management practices at Mkuranga hospital. The chapter shows the information collected from respondents, analyzes, and explains how it answers the research questions. The data were collected using questionnaires and interview from hospital staff. The results are presented in a simple and clear way using explanations and percentages so that they can be easily understood.

4.1Respondent Rate

The study targeted 25 respondents from different department within the Mkuranga hospital. Out of 20 questionnaire distributed to respondents,15 questionnaires were successfully returned and filled correctly, representing a response rate 90%. According to Kothari 2019, respondents rate refers to the proportion of respondents who successfully participate in a study out of the total number targeted. A high response rate increases the reliability and validity of research findings.

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Table 4.1 Response rate of respondents (N=25)

Category	Frequency	Percentage%
Responded	**18**	**72**
Non responded	**7**	**28**
Total	**25**	**100**

Source: Field Data (2026)

The finding in table 4.1 indicates that 18 are all respondents that are participated in the study, resulting in a response rate of 72%. According to Ngulube and Mtula (2005), they talk about respondent rate they say that" A high response rate increases the credibility and reliability of research findings because it reflects adequate participation from selected sample. In this study, all 25 targeted respondents are not participated well, resulting in a response rate of 90% which was considered excellent for data analysis. This response rate was considered adequate for generating reliable findings because there are some respondents they provide the required information.

4.2 Demographic characteristics of respondents

Demographic characteristics refer to the social and personal attributes of respondents that help researchers understand the composition of the study population and determine whether respondents possess relevant experience regarding the study topic. (Creswell, 2018). This section explains the background information of the respondents. Understanding this information helps to know the types of people who provided the data. In this study, demographic characteristics included age, gender, educational level, and work experience. The following are the subsections that provide are details account of this information.

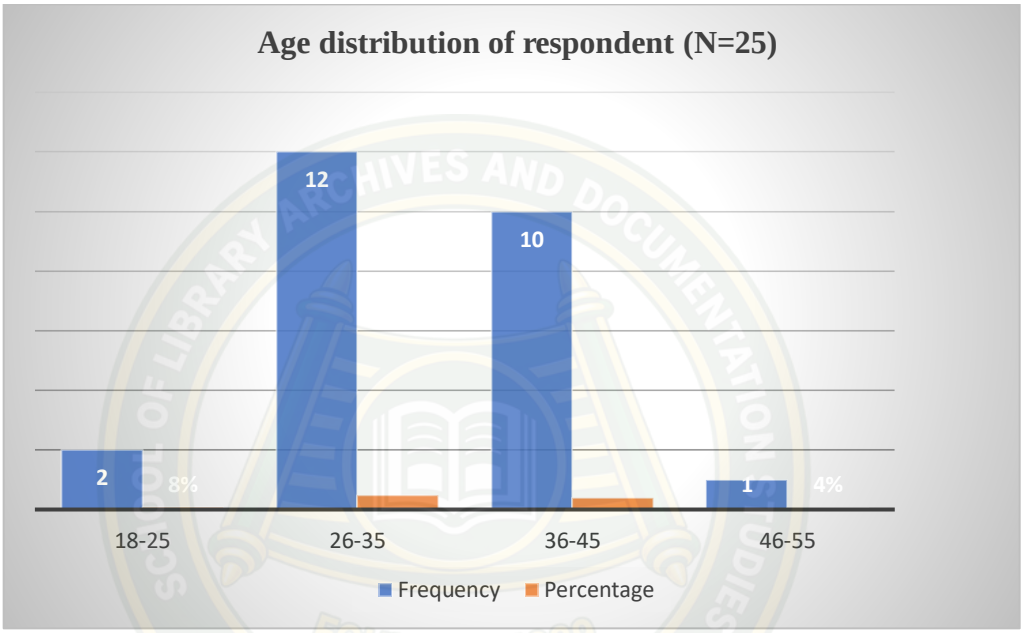
4.2.1 Composition of respondents by age.

Respondents in the present study were requested to specify their age groups. This aimed to determine the presentation of different age categories among respondents involved in the study. A summary of the results is provided in Table 4.1. The study aimed to determine

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the age distribution of the respondents. Understanding the age groups of the participants helps in assessing administrative records management practices in enhancing health care service delivery are as presented in table below.

Figure 2.3 Age distribution of respondent (N=25)



Source; Field data (2026)

The table 4.2 presents the distribution of participant categorized the age. The data results showed that 48% of respondents were age between 26-35 years, 40% were between 36-45 years, 8% were between 18-25 years, and 4% were between 46-55 years. This indicates that the majority of respondents were relatively young and within the active working age group. Employees in the 26-35 age group are often energetic, adaptable, and more open to learning and using new technologies, such as electronic records management system. This presence of respondents age 36-45 and above 46-55 years is also important because these individuals are likely to have more work experience and a deeper understanding of traditional records management practices over time and can provide valuable insights into both past and current systems. According to Rutta (2022), age distribution is an important demographic characteristic because it helps to show the age categories of respondents

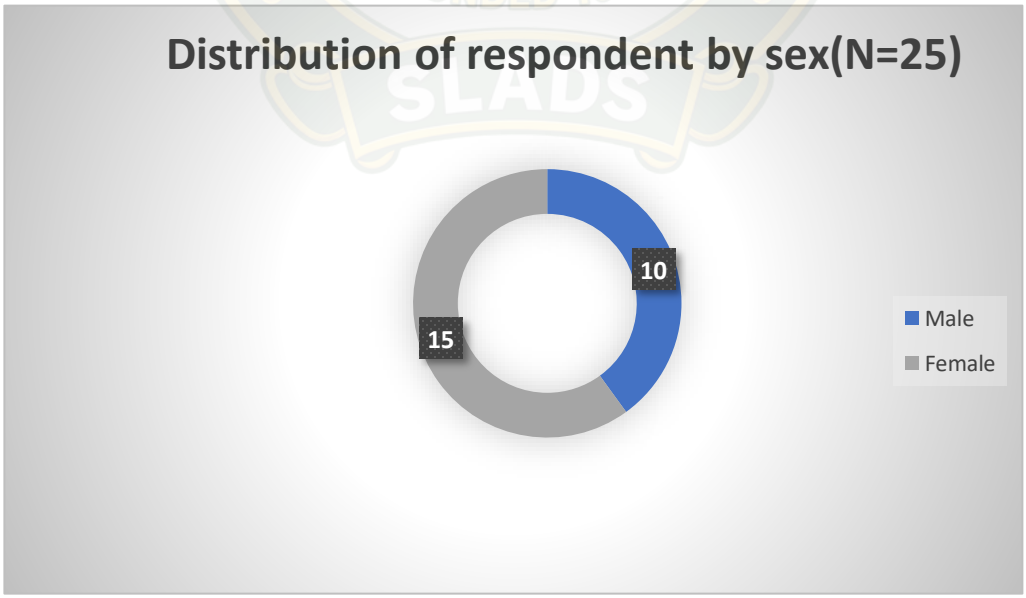
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involved in a study. It enables the researcher to understand whether respondents are young, middle aged, or older, and how their age may influence their knowledge, experience, attitudes, and performance in their work. Therefore, analyzing respondents by age helps the researcher interpret the findings correctly and determine whether age has an influence on administrative records management practices and health care service delivery at Mkuranga Hospital. Therefore, the combination of younger and older respondents provides a balanced view, combining innovation and experience. This diversity strengthens the quality of data collected in the study.

4.2.2 Distribution of Respondents by Sex

The study also wanted to identify the sex of categories of respondents. This information is very important According to Kadu (2022), there is significance of providing insight to the background of the study participant. This information is crucial as it provides a basic for understanding the diversity of the sample population and ensures that the study consider perspectives from both gender and the findings are as presented in table below.

Figure2.4 Distribution of respondents by sex (N=25)



Source; Field data, (2026)

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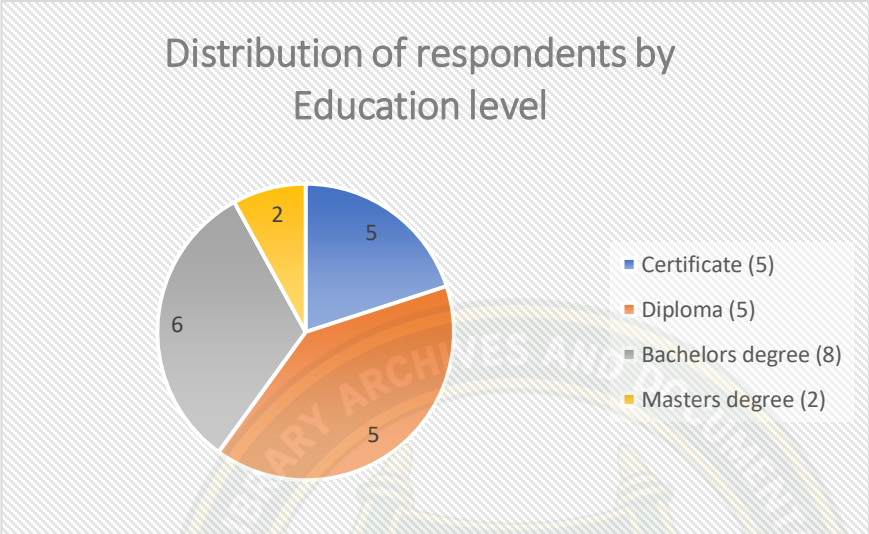
The finding shows that 10 respondents (40%) were male while 15 respondents (60%) were female. The results indicate a balanced representation of both sexes, suggesting that the views collected reflect perspectives from male and female employees at Mkuranga Hospital. This distribution is important because it reflects the actual composition of many healthcare workforces, where female staffs often make up a significant percentage, especially in nursing and administrative roles. The inclusion of both male respondents ensures that the study captures a wide range of perspectives and experiences related to record management practices. Furthermore, having a balanced gender representation helps to reduce bias in the findings, as both men and women may have different roles, responsibilities, and experiences in handling hospital records. According to Crewsell and Kothari (2018), gender was included in this study because male and female employees may have different responsibilities, experiences, and perceptions regarding administrative records management. Therefore, understanding the gender distribution helped the researcher determine whether the study included views from both groups and whether the findings reflected the diversity of the study population. Therefore, the responses collected can be considered more comprehensive and reliable. The findings suggest that Mkuranga Hospital has more female involved of management of records and archives than male.

4.2.3 Education level of respondents

The study aimed to determine the educational levels of the respondents. This information was essential for understanding whether the level of educational. Educational level is important because it influence respondents understanding of records management principles and administrative procedures at Mkuranga Hospital have an adequate level of education for them so as to provide efficiency managing, they are records according to they are working place.

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Figure 2.5 Education level of respondents (N=25)



Source, Field Data (2026)

This finding reveal that 5 respondents (20%) possessed certificate qualifications, 5 respondents (20%) held diploma, 6 respondents (32%) had bachelor's degrees, and 2 respondents (8%) had master's degrees. The results suggest that most respondents possessed formal education relevant to their duties and were therefore capable of providing reliable information regarding administrative records management practices. Having a diploma or degree means that respondents are likely to have formal training and better understanding administrative procedures, including records management practices. However, the presence of respondents with certificate is also important, as they often represent support staff who are directly involved in handling physical records on a daily basis. Their practical experience provides valuable insights into the real challenges faced in records management. According to Mugenda (2003), says that education level is an important demographic characteristic because it helps researcher understand whether respondents have the knowledge and skills needed to provide reliable information about the study. Respondents with different education levels may have different experiences and understanding of administrative records management practices. Overall, the mix of

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different education levels ensures that the study capture both theoretical knowledge and practical experience. From this situation provides service delivery at Mkuranga hospital.

4.3 Assessment of existing practices for managing records at Mkuranga hospital.

The first objectives aimed at assessing the existing practices used in managing administrative records at Mkuranga hospital. The study aimed to assess the following records creation and collection, Records classification and filling system, Records Storage and Preservation. Administrative records are important because they support decision making, communication, accountability, and service delivery within the hospital.

4.3.1 Records creation and collection

The successful of any organization either public or private it depends on they are good creation of they are records. The study found that administrative records are created and collected daily in different departments such as administrative, finance, procurement, human resource, and medical administration. These records include official letters, reports, attendance registers, payment vouchers, procurement documents, staff files, meeting minutes, and correspondence. Most respondents explained that every department is responsible for creating records related to its daily activities before submitting them to the registry or responsible records officers for filing and storage.

Table 4.3 Records creation and collection.

Record creation and collection	Frequency	Percentage%
Electronic	**10**	**55**
Paper	8	45
Total	18	100%

Source, Field Data (2026)

The findings further revealed that 8 respondents (45%) agreed that records creation and collection by using paper practices are well established in the hospital. This indicates that most administrative activities are properly documented, which helps maintain institutional

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memory and supports daily operations. However, 10 respondents (55%) explained that some departments still using electronic system for keep records independently before transferring them to the registry, causing delays and poor coordination. According to ISO 15489-1 (2016), records should be created as evidence of organizational activities and should be captured into an official records management system immediately after creation. Likewise, Ngoepe and Ngulube (2016), state that proper records creation improves accountability, transparency, and organizational performance.

4.3.2 Records classification and filling system.

The study established that the hospital uses records classification and filing systems to organize administrative records according to departments, subjects, file numbers, and dates. Proper classification enables records officers to identify files quickly and retrieve them without unnecessary delays. Most respondents reported that file labels and file indexes are used to simplify filing and retrieval processes.

Table 4.4 Records classification and filling system

Records classification and filling system	Frequency	Percentage%
Numerical	2	12
Alphanumerical	7	38
Geographical	3	16
Alphabetical	6	34
Total	18	100%

Source, Field Data (2026)

The findings indicated that 2 respondents (12%) agreed that records are classified and filed according to established procedures by using numerical. However, 7 respondents (38%) agreed that the records are using alphanumerical that it can help to avoid some misfiling or misplacement of the information. Also 3 respondents (16%) stated that they are using geographical. However, 6 respondents (34%) agreed that they are using alphabetical in order to show the location of the information and to facilitates easy

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accessibility and retrieval of documents. According to ISO 15489-1 (2016), records classification provides a systematic arrangement that facilitates storage, retrieval, and disposal of records. Similarly, Read-Smith et al. (2010) explain that a good filing system improves efficiency by reducing retrieval time and minimizing the risk of misplaced records. This records classification system and filling system it can help to avoid misfiling occasionally occurs due to heavy workloads, shortage of trained personnel, and failure to follow filing procedures consistently. Such problems sometimes make it difficult to locate important files within a short time.

4.3.3 Records Storage and Preservation

The study found that administrative records are stored in filing cabinets, shelves, registries, and records rooms, while electronic records are stored in computers and external devices. Sensitive documents are kept in lockable cabinets, while active files remain in departmental offices for daily use. The hospital has made efforts to preserve records by protecting them from dust, moisture, insects, and unauthorized access.

Table 4.5Records Storage and Preservation

Records Storage and Preservation	Frequency	Percentage%
Cabinets	8	45
Computers	4	22
Shelves	6	33
Total	18	100

Source, Field Data (2026)

The findings showed that 8 respondents (45%) agreed that storage and preservation practices are satisfactory by using cabinets. Also, 4respondents (22%) agreed that they are used some tools like computers to preserve the information. Also reported inadequate storage space, overcrowded registries, and insufficient storage equipment. However, 6 respondents (33%) agreed that they are used shelves in order to protect the information or documents with dust or inserts and to categorized and proper classification of records.

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These conditions increase the possibility of records deterioration, damage, or loss, especially for paper-based records that require proper environmental conditions. According to ISO 15489-1 (2016), records should be stored under conditions that protect them from deterioration and unauthorized access. Likewise, Katuu (2015) argues that proper storage and preservation ensure records remain reliable, authentic, and usable throughout their life cycle.

4.4 Extent to Which Mkuranga Hospital Adheres to Legal and Regulatory Framework in Managing Administrative Records.

The second objective examined the extent to which Mkuranga Hospital adheres to legal and regulatory requirements in managing administrative records. A legal and regulatory framework consists of laws, policies, regulation, standards, and guidelines that direct how records should be created, classified, maintained, stored, protected, retained, and disposed of within an organization. The results of the observation review that at Mkuranga hospital they have legal framework but they don't know how to guide those legal framework of the records it's like procedure manual, policy. This finding suggests that compliance with these frameworks promotes accountability, transparency, proper governance, and the protection of organizational information. According to Kashaija and Ndumbalo (2020), legal and regulatory frameworks provide the foundation for effective records management because they establish standardized procedures for the creation, maintenance, accessibility, security, retention, and disposal of records. The authors further argue that compliance with legal requirements enhances institutional accountability, supports informed decision making, protects records from unauthorized access or loss, and ensures organizations meet statutory obligations. In the context of Mkuranga Hospital, adherence to legal and regulatory requirements is important because administrative records support planning, financial management, procurement, Human resource administration, and the delivery of quality health care services. Therefore, the hospital is expected to comply with national laws and policies governing records management to ensure that records remain authentic, reliable, accessible, and secure.

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One respondent explained that;

The hospital has legal and regulatory frameworks for records management, but many staff members are not fully aware of how to implement these frameworks in their daily work.

4.5 Challenges Hindering Effective Administrative Records Management Practices at Mkuranga Hospital

The third objective of this study sought to identify the challenges hindering effective administrative records management practices at Mkuranga Hospital. Effective administrative records management is essential because it ensures that records remain authentic, reliable, accessible, and usable throughout their life cycle, thereby supporting effective decision making and quality health care service delivery ISO (2016), Ngoepe and Ngulube (2016). However, the findings revealed that the hospital experiences several challenges that affect the proper management of administrative records. The major challenges identified by respondents included inadequate storage facilities, lack of modern technology, and insufficient staff training.

Table 4.6 Challenges Hindering Effective Administrative Records Management Practices at Mkuranga Hospital

Challenges	Frequency	Percentage%
Inadequate Storage Facilities	4	22
Lack of Modern Technology	6	34
Insufficient staff training	8	44
Total	18	100

Source, Field Data (2026)

The data presented in table 4.6 to outline the challenges that hindering the effective administrative records management practices at Mkuranga Hospital. Specially, the table

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reveals that4 respondents (22%) reported inadequate storage facilities, while 6 respondents (34%) reported lack of modern technology. Additionally, 8 respondents (44%) noted that the employee they should not get some training on how they should support to manage the records or information. The findings revealed that insufficient staff training was the most significant challenge, reported by 8 respondents (44%). This indicates that many staff members responsible for handling administrative records had not received adequate knowledge and professional skills in records management. As a result, records were not always classified, filed, stored, or retrieved correctly. Poor training also reduced staff awareness of records management policies, legal requirements, and records retention procedures. According to Katuu (2016), trained records personnel are essential for ensuring that records are managed professionally and remain reliable throughout their life cycle. Likewise, Ngoepe and Ngulube (2016) argued that continuous staff training improves records management practices, enhances accountability, and increases organizational efficiency.

One respondent explained:

"Over working due to shortage of staff makes poor performance within the organization."

Furthermore, the lack of modern technology, which was reported by 6 respondents (34%). The findings showed that administrative records at Mkuranga Hospital were still managed mainly through manual paper-based systems due to limited computers, inadequate electronic records management systems, and unreliable internet services. These conditions slowed records creation, filing, retrieval, and sharing among departments. Staff spent a considerable amount of time searching for files, which affected decision-making and delayed service delivery. According to Katuu (2018), modern electronic records management systems improve information accessibility, security, efficiency, and service delivery in healthcare institutions. Similarly, ISO 15489-1 (2016) recommends the use of appropriate technologies to improve records management, information accessibility, and long-term preservation of records.

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Another respondent state that:

"The number of records continues to increase every year, but the available storage space and preservation materials are insufficient to accommodate all records properly."

The findings further showed that inadequate storage facilities were another important challenge affecting records management. Respondents explained that records rooms were overcrowded and had insufficient cabinets and shelves for proper storage of files. Consequently, some records were exposed to dust, moisture, insects, and physical damage, increasing the possibility of file loss and delayed retrieval. Poor storage conditions also reduced the lifespan of important administrative records and affected organizational efficiency. According to Marutha (2016), inadequate storage facilities contribute to poor preservation, increased deterioration, and difficulties in retrieving organizational records. Likewise, ISO 15489-1 (2016) emphasizes that organizations should provide appropriate storage environments to protect records from damage and ensure their availability throughout their life cycle.

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CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter provides the synthesis of the findings, draws conclusions, and offers recommendations based on the results of the study. The research aimed to assess administrative records management practices in enhancing health care service delivery in Mkurang Hospital. The study was guided by the following three specific objectives

i. To assess the existing practices for managing administrative records at Mkuranga Hospital.
ii. To examine to which extent Mkuranga hospital adhering to the available legal and regulatory framework in managing administrative record
iii. To identify the challenges hindering effective administrative records management practices at Mkuranga hospital.

The research successfully accomplished its stated specific objectives through the utilization of various methodologies, including questionnaires, interviews and observations. These methodologies facilitated the gathering of both primary and secondary data aligned with the study's aims. Additionally, the research developed specific questionnaire, interviews formats, and an observation checklist, which served as a strategic framework for achieving the study's objectives.

5.1 Summary

The summary of this study is provided in chronological order using study specific objectives. The summary key findings are presented below,

5.1.1 Existing practices for managing administrative records at Mkuranga Hospital.

The findings revealed that Mkuranga Hospital performs several records management activities including records creation, classification, filing, storage, preservation and

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retrieval. Administrative records are created daily in departments such as procurement, finance, administration and human resource. Although records management procedures exist, some departments still experience poor filing practices and delays in records retrieval due to weak coordination and limited resources. This scenario has resulted in significant challenges, including the misfiling or misplacement of the information, delays in fie retrieval. These findings are consistent with ISO (2016), which emphasizes that effective records management should cover the entire records life cycle.

5.1.2 To which extent Mkuranga hospital adhering to the available legal and regulatory framework in managing administrative record

The study further found that the hospital has legal and regulatory frameworks such as records management policies, procedure manuals and government regulations. However, many staff members have inadequate knowledge of these frameworks, resulting in inconsistent implementation. Kashaija and Ndumbaro (2020) explain that compliance with legal and regulatory requirements promotes accountability, transparency and effective management of organizational records.

5.1.3 Challenges hindering effective administrative records management practices at Mkuranga hospital

The study also identified several challenges affecting administrative records management practices. These include inadequate storage facilities, lack of modern technology, insufficient staff training, shortage of financial resources, poor records security, absence of regular monitoring and weak implementation of records management policies. These challenges reduce the efficiency of records management and negatively affect health care service delivery. Similar findings were reported by Marutha (2016), who observed that poor records management reduces organizational performance and service quality.

Finally, respondents proposed several measures for improving administrative records management. These include providing regular staff training, increasing budget allocation for records management activities, introducing electronic records management systems,

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improving storage facilities, strengthening supervision and ensuring compliance with legal and regulatory frameworks. According to ISO (2016), continuous improvement of records management systems enhances accountability, efficiency and organizational performance.

5.2 Conclusion

The study concluded that administrative records management plays a significant role in improving health care service delivery at Mkuranga Hospital. Proper management of records supports effective communication, accountability, planning, financial management, procurement activities and informed decision making within the hospital. Administrative records also facilitate easy retrieval of information required for daily hospital operations. The study further concluded that although Mkuranga Hospital has adopted some records management practices and operates under existing legal and regulatory frameworks, the implementation of these frameworks is still inadequate. Many staff members have limited knowledge of records management standards and policies, which affects compliance with established procedures. Kashaija and Ndumbaro (2020) argue that effective implementation of legal frameworks is essential for protecting records and improving institutional accountability. Moreover, the study concluded that inadequate storage facilities, shortage of trained personnel, limited use of information technology and insufficient financial resources remain major barriers to effective records management. These challenges increase the risk of records loss, delays in retrieving information and poor service delivery to patients. Overall, the study concludes that strengthening administrative records management practices will significantly improve the quality of health care services, operational efficiency and accountability at Mkuranga Hospital. Effective records management remains an important component for achieving quality health services and organizational development (ISO, 2016; Ngoepe & Ngulube, 2016).

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5.3 Recommendations

The study draws its recommendations from its findings in order to improve the administrative records management practices in enhancing health care service delivery at Mkuranga Hospital.

5.3.1 Training and seminars

The management of Mkuranga Hospital ought to give the employee training and seminars on administrative records management as a compulsory requirement. The Hospital management should support to put some budget in order to get education on how they can protect they are information. This approach will guarantee that an adequate budget is allocated annually for records practitioners to participate in relevant training and seminars. The management and other users they should also attend records management sessions at least twice a year to foster a shared understanding of best practices in administrative records management.

5.3.2 Compliance to records management legal and regulatory frameworks

The results of this research indicate a lack of compliance to legal and regulatory frameworks governing records management. Consequently, it is recommended that management prioritize the availability of these legal frameworks for administrative records, ensuring thy are disseminated to all records users and custodians, and that their implementation is strictly enforced. If executed properly, this approach will facilitate the effective management of records. Records officers should ensure that records are properly created, classified, filed, stored and disposed of according to approved records management procedures. They should also maintain accurate records registers and retention schedules to facilitate efficient retrieval of information. Records staff should continuously update their professional knowledge by participating in workshops, seminars and short courses related to records and archives management. Continuous professional development improves employees' competence and organizational performance (Marutha, 2016).

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5.3.2 Provision of modern Records Management facilities

The management of Mkuranga Hospital should provide adequate records storage facilities and modern records management technologies. This includes enough filling cabinets, shelves, computers, and electronic records management systems. The hospital should also improve internet services and provide regular maintenance of records equipment. These improves will help staff to store, retrieve, and protect administrative records more efficiently, reduce the loss of records, and improve health service delivery.

5.3.3 Regular Monitoring and Evaluation of Records Management Practices

The management of Mkuranaga Hospital should conduct regular monitoring and evaluation of administrative records management practices to ensure that records are properly created, classified, stored, and maintained. Regular inspections and performance reviews will help identify weaknesses, improve compliance with records management procedures, and ensure continuous improvement in service delivery.

5.4 Areas for Further Studies

This study focused only on Mkuranga Hospital, further studies should be conducted in other district, regional and referral hospitals to compare records management practices across different levels of health facilities. Potential areas for future research may include, but are not limited to;

i. To examine the effectiveness of records management systems in improving health care service delivery in Tanzania.
ii. Another area for future research is the impact of staff training on records management performance in public hospitals.
iii. Researchers may also investigate the relationship between records security and patient confidentiality in Tanzanian health institutions.

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APPENDIX I

TIME SCHEDULE

This time schedule shows what will be done and at what time. In general time schedule reveal the activities that will be done from the starting point to the final stage of the study indicating the specific time for their basis of operations. The time schedule or work plan schedule in this research will be for six weeks as follows,

ACTIVITIES	1st **MONTH**	2nd **MONTH**	3rd **MONTH**	4th **MONTH**	5th **MONTH**	6th **MONTH**
Report at the study area and get familiarization						
Distribution of questionnaire and interviewing respondents						
Observation the situation and collecting questionnaire and data analysis						
Data interpretation and report writing.						

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APPENDIX II

RESEARCH BUDGET

In order to accomplish good research stated we should work under the following budget,

S/N	ACTIVITY	COST ANALYSIS	TOTAL COST
	Transport	From home to Mkuranga Hospital 4000x30	120,000/=
	Food allowance	6000x30	180,000/=
	Stationary	Ruled paper 2 ream Pen, Pencils, Ruler, Rubber, Stapler &Note book	26,000/= 20,000/=
	Secretarial service	Typing and printing 2x73pages@1000 Photocopy 73x2@200	80,000/= 16,000/=
	Binding	Hard cover 2x2@12000 Soft cover 2x2@500	48,000/= 2,000/=
	TOTAL		492,000/=

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APPEENDIX III

A QUESTIONNAIRE FOR HEALTH WORKERS/STAFF

Dear Sir/ Madam

I HENRY JOSEPH a student at the school of library archives and documentation studies (SLADS) Mkuranga, studying an ordinary diploma course in Records and archives management. I am carrying out study on '**An assessment of administrative records management practices in enhancing health care service delivery at Mkuranga Hospital'**. I kindly request you to answer question which are provided in questionnaire forms by making a tick and answer in the space provided and return to a researcher. The data collected and information obtained through this questionnaire will be treated as confidential and will be used for academic purpose only.

1. What is your gender?
   a) Male ( )
   b) Female ( )
2. What is your age category?
   a) 18 – 25 ( )
   b) 26 – 35 ( )
   c) 36 – 45 ( )
   d) 46 - 55 ( )
3. What is your education level?
   a) Certificate ( )
   b) Diploma ( )
   c) Bachelor degree ( )
   d) Master's degree ( )
4. How long have you been working at this health facility?
   a) Less than 1 year ( )
   b) 1 – 3 years ( )

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c) 4 – 6 years ( )

d) 7 – 10 years ( )

e) More than 10 years ( )

5. How do you rate the way administrative records are organized in hospital?

a) Very good ( )

b) Good ( )

c) Average ( )

d) Poor ( )

e) Very poor ( )

6. What level of training have you received about records management?

a) Very high training ( )

b) High training ( )

c) Moderate training ( )

d) Low training ( )

e) No training ( )

7. To what level does good records management help improve health care services?

a) High level ( )

b) Moderate level ( )

c) No improvement ( )

d) Very high level ( )

e) Low level ( )

8. Do these challenges affect service delivery?

a) Yes ( )

b) No ( )

c) Partially ( )

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9. What do you think is the most important action needed to improve records management at this facility?
    a) Training more staff on records management principles and practice. ( )
    b) Introducing or upgrading an electronic health record system. ( )
    c) Developing and enforcing a clear records management policy. ( )
    d) Hiring dedicated and qualified records management personnel. ( )
    e) Increasing financial resources allocated to records management. ( )

10. What do you think is the most important action needed to improve records management at this facility?.....
11. In your opinion, how much does poor records management affect the quality of patient care at this facility?.....
12. Have you received any formal training on health records management?.....
13. What type of records storage system is mainly used at this facility?.....

14. What are the most challenges facing health records management practices at Mkuranga Hospital?.....

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APPENDEX IV

INTERVIEW QUESTION FOR HOSPITAL ADMINISTRATORS.

1. What types of administrative records are kept in the hospital?.....
2. What system is used to manage records in the hospital (manual, electronic or both)?.....
3. Are there any rules or policies that guide records management in the hospital?.....
4. In what ways does records management help improve health care services?.....
5. What challenges does the hospital face when managing administrative and patient records?.....
6. How does poor records management affect hospital decisions and service delivery?.....
7. What resources (such as equipment, technology, or staff) are available to support records management?.....
8. What improvements do you think should be made to strengthen records management in the hospital?.....

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APPENDIX V

OBSERVATION CHECKLIST

Date of Observation: _____ Time: _____

Area Observed: _____

Instructions;

i. Tick **YES** if performed and **NO** if they do not.

ii. Use the comments/ notes column to record observation.

S/N	ITEM TO BE OBSEERVED	YES	NO	COMMENTS
1	Filing cabinets/shelves are properly labeled.			
2	Availability of legal and regulatory requirements for records management available at Mkuranga Hospital.			
3	The number of staff managing records.			
4	Records control tools used at Mkuranga Hospital to control the movement of the records.			
5	Records are arranged in an orderly manner.			
6	Records can be retrieved quickly when needed.			
7	Staff can locate records without difficulty.			
8	Records are protected from dust, moisture and pests.			

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9	Adequate equipment (shelves, cabinets) is available.			

General Observations / Additional Notes:

.....

.....

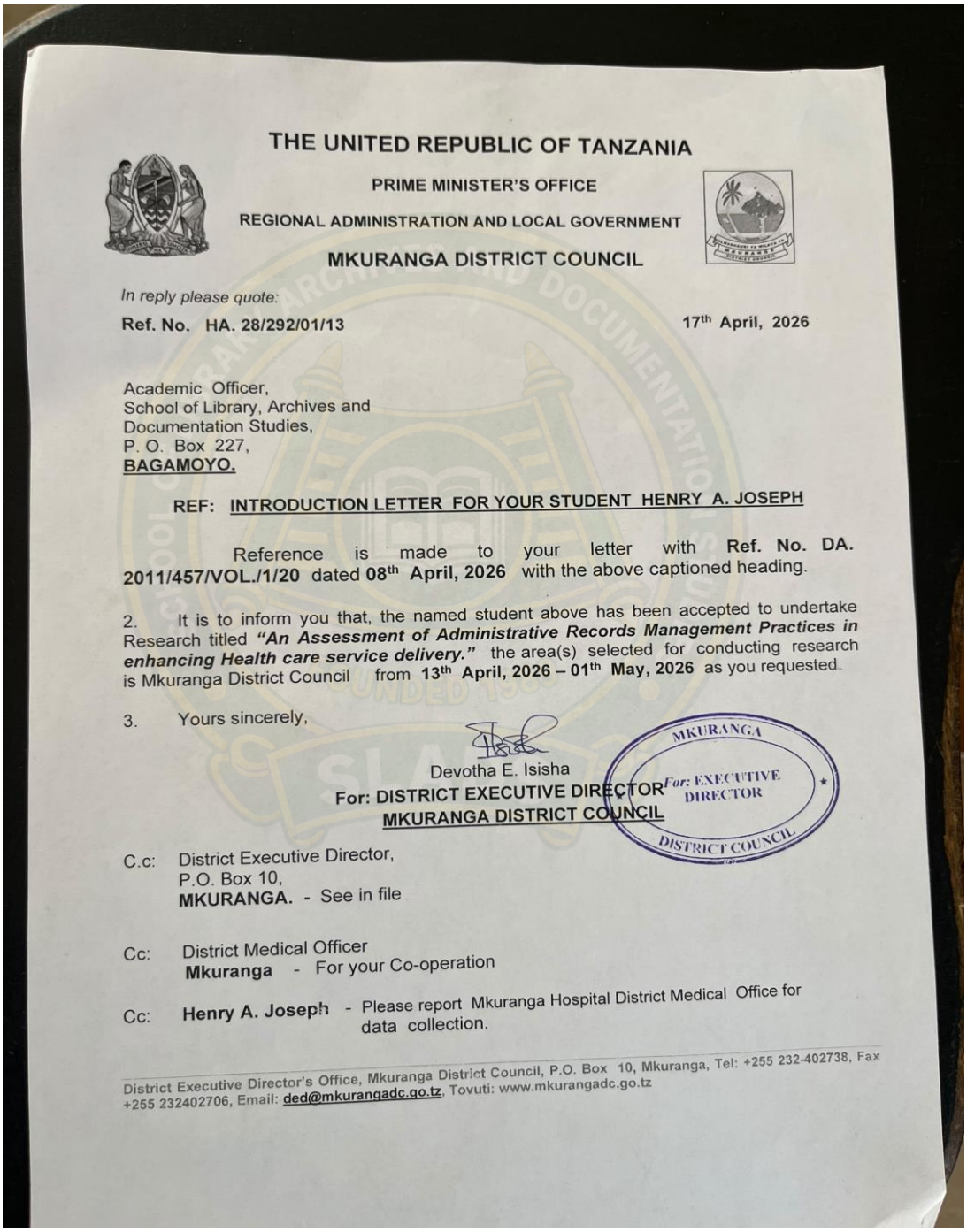
.....

Name of Observer: _____ Signature: _____

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APENDIX VI

APPROVAL LETTER



THE UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

MKURANGA DISTRICT COUNCIL

In reply please quote:

Ref. No. HA. 28/292/01/13 **17th April, 2026**

Academic Officer,
School of Library, Archives and
Documentation Studies,
P. O. Box 227,
BAGAMOYO.

REF: INTRODUCTION LETTER FOR YOUR STUDENT HENRY A. JOSEPH

Reference is made to your letter with **Ref. No. DA. 2011/457/VOL./1/20** dated **08th April, 2026** with the above captioned heading.

2. It is to inform you that, the named student above has been accepted to undertake Research titled ***"An Assessment of Administrative Records Management Practices in enhancing Health care service delivery."*** the area(s) selected for conducting research is Mkuranga District Council from **13th April, 2026 – 01th May, 2026** as you requested.

3. Yours sincerely,

Devotha E. Isisha
For: DISTRICT EXECUTIVE DIRECTOR
MKURANGA DISTRICT COUNCIL

MKURANGA For: EXECUTIVE DIRECTOR DISTRICT COUNCIL

C.c: District Executive Director,
P.O. Box 10,
MKURANGA. - See in file

Cc: District Medical Officer
Mkuranga - For your Co-operation

Cc: **Henry A. Joseph** - Please report Mkuranga Hospital District Medical Office for data collection.

District Executive Director's Office, Mkuranga District Council, P.O. Box 10, Mkuranga, Tel: +255 232-402738, Fax +255 232402706, Email: ded@mkurangadc.go.tz, Tovuti: www.mkurangadc.go.tz

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