Pursuing better health care delivery at district level

In the urban and rural districts of Tanzania’s Dodoma Region a process was adopted for identifying and solving problems of health care delivery. In a single year, considerable improvements were secured in both teamwork and attitudes towards coping with managerial obstacles.

The United Republic of Tanzania has succeeded in providing reasonably accessible health services to its population, although their quality is variable, partly because funds are limited. In 1990 an attempt was made to identify obstacles to health care delivery in Dodoma Region which could be tackled with existing resources through district action research and education (1). The urban district concentrated on staff motivation, while the rural district focused on supervision. District health management teams identified the underlying causes of their respective problems and suggested solutions. On this basis each district produced a plan of action for one year (2).

Plans of action

The plan of action for the urban district concentrated on increasing the availability of continuing education for health workers, establishing a library, preparing guidelines for good performance, and developing a system to recognize and reward the best workers. By contrast, the plan for the rural district focused mainly on improving the preparation and follow-up of supervisory activities through a workshop, morning sessions, and monthly meetings involving members of the district health management team.

The working groups that identified the areas for intervention evaluated the implementation of the plans after one year. In each district a task force of four people collected the necessary information and presented the results of evaluation to its working group. Discussions were held on the successes and failures in implementation; problems and their possible causes and solutions were identified in order...
to prepare the plan of action. The evaluation provided a basis for replanning in the light of an examination of objectives, targets, activities and resources.

Levels of satisfaction were measured by means of a scoring system (see Table). Differences in scores between baseline and follow-up questionnaires were assessed by calculating the means and applying Student’s t-test.

The secretariats of the district health management teams were asked to follow up and document the implementation of the plans, and to prepare quarterly progress reports for the regional medical officer. Each health management team held a workshop at which it presented and discussed its plans and developed its strategy for tackling the issue it had selected.

### Urban

In the urban district, staff motivation was measured by means of a job satisfaction questionnaire used the previous year (3); it was administered to the health management team and the health workers in the units that had been included in the baseline study. The respondents included people who had and others who had not completed the baseline questionnaire.

Documents in the district health office were reviewed and interview check-lists were developed to assess workshop activities, the numbers of classes held in health units and during supervisory visits, and distance education. An observational check-list was used to evaluate district library facilities and their utilization. The preparation of guidelines on performance was checked and the recognition and rewards given to the best health units and staff were reviewed by examining documents in the district office.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score²</th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest of work</td>
<td></td>
<td>3.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Planning of own work</td>
<td></td>
<td>3.3</td>
<td>3.3</td>
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<tr>
<td>Responsibility for results of work</td>
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<td>3.3</td>
</tr>
<tr>
<td>Application of training</td>
<td></td>
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<td>3.2</td>
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<tr>
<td>Community respect</td>
<td></td>
<td>3.2</td>
<td>3.1</td>
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<tr>
<td>Colleagues’ respect</td>
<td></td>
<td>3.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Patients’ appreciation</td>
<td></td>
<td>3.1</td>
<td>3.0</td>
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<tr>
<td>Competent supervision</td>
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<td>3.0</td>
<td>2.9</td>
</tr>
<tr>
<td>Fixing own objectives</td>
<td></td>
<td>3.0</td>
<td>2.9</td>
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<tr>
<td>Allocation of precise work objectives</td>
<td></td>
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<tr>
<td>Challenging work</td>
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<tr>
<td>Job security</td>
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<tr>
<td>Caring supervision</td>
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<td>2.7</td>
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<td>Competent colleagues</td>
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</tr>
<tr>
<td>Working conditions</td>
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<td>2.7</td>
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<tr>
<td>Fair treatment by superiors</td>
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<td>2.5</td>
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<tr>
<td>Safety at work</td>
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<tr>
<td>Setting objectives by discussion</td>
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<td>2.4</td>
<td>2.6</td>
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<td>Information on work performance</td>
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<tr>
<td>Perceived value of work</td>
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<td>3.2</td>
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<tr>
<td>Prospects of continuing education</td>
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<td>2.2</td>
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<tr>
<td>Pension</td>
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<tr>
<td>Good equipment</td>
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<td>1.8</td>
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<tr>
<td>Pay</td>
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<tr>
<td>Prospects of promotion</td>
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<tr>
<td>Mean</td>
<td></td>
<td>2.4</td>
<td>2.6</td>
</tr>
</tbody>
</table>

*Scores are: 1 = great dissatisfaction; 2 = some dissatisfaction; 3 = some satisfaction; 4 = great satisfaction.*

The job satisfaction questionnaire was administered to 106 health workers, 76% of them female, amounting to approximately 20% of the total. Nurses comprised 69% of the respondents, and 44% of the latter were working in peripheral health units,
the remainder in the city; 88% were aged under 40, 84% were either married or lived with their families, and 16% lived alone; 56% had two or more types of dependant, for example, spouse and children.

The plan of action for the urban district concentrated on increasing the availability of continuing education for health workers, establishing a library, preparing guidelines for good performance, and developing a system to recognize and reward the best workers.

Of the people who were respondents in 1990, 74% completed the follow-up questionnaire. There were no significant differences with respect to demographic characteristics or job category and satisfaction between those who answered the questionnaire in both years and those who answered only the follow-up questionnaire.

The Table shows that the average score for job satisfaction increased from 2.4 in 1990 to 2.6 in 1991. There were significant increases in satisfaction regarding perceived value of work, fringe benefits, transport and prospects for promotion, and nonsignificant gains in respect of satisfaction with safety at work, work challenges, job security, competence of colleagues, and the setting of objectives in discussion. On the other hand, satisfaction with housing declined substantially.

For the areas given special attention in the plan of action there was increased satisfaction in regard to perceived fairness of treatment by bosses. There was a lesser degree of improvement in respect of prospects of continuing education and caring supervision; a slight decline occurred in relation to the competence of supervision.

When satisfaction was examined as a dichotomous variable the average satisfaction level among city health workers increased from 46% to 58%, whereas among peripheral workers it decreased from 63% to 60%. As regards working conditions the city health workers were more satisfied in 1991 (76%) than in 1990 (49%), while at the periphery the level of satisfaction dropped from 65% in 1990 to 43% in 1991. The same trend was observed in respect of the competence of supervision, the fairness of treatment by superiors, the allocation of precise work objectives, and the involvement of staff in the planning of their work.

In most areas, supervisors thought that the persons supervised were more satisfied than was actually expressed by the health workers themselves. However, the health workers’ satisfaction was greater than the supervisors thought in the areas of being kept informed, planning their own work, transport and housing.

A district library was established with a table, two chairs, a cupboard and 175 books. However, a table, six chairs and a bookshelf which were in the plan have not been supplied. The library is not well utilized by the lower grades of staff because of language problems, there being only a few books in Swahili. Little effort was made to contact potential donor organizations, and only a limited number of books were received from the Istituto Superiore di Sanità in Italy and the African Medical and Research Foundation. The person managing the library does so on the basis of guidelines developed by the district health management team.
With regard to continuing education, all health units were requested to start discussion classes. However, only the two health centres and six of the 23 dispensaries were actually holding them regularly at the time of evaluation. No discussions were held after supervision by the health management team, and no distance education was organized.

The health management team revised the guidelines for rewarding workers belonging to the Organization of Tanzanian Trade Unions and the Ministry of Health and produced its own guidelines for local use, which were distributed to all health units. On this basis, recognition and rewards were given to some health workers; no list of recipients was, however, available.

The working group made the following suggestions, on the basis of which a plan of action for a year was developed.

- An effort should be made to improve the knowledge and skills of the members of the district health management team and of the heads of health units, in respect of resource management and the process of district action research and education.
- Opportunities for continuing education should be increased by strengthening discussion classes in health units, holding discussions after supervisory visits, distributing health learning materials, and establishing distance education.
- More space and more books should be provided for the district library.
- The recognition, reward and feedback systems should be improved.

Rural

In the rural district the members of the health management team were interviewed in 1991 using the same questionnaire as the previous year to assess their satisfaction regarding the preparation of, participation in, and follow-up of supervision. Documents and reports in the district health office were examined to assess the workshop activities of the health management team, the establishment of morning sessions and monthly meetings of the team, and the preparation and follow-up of supervision, reports and feedback. The heads of six health units were interviewed in order to ascertain the response of the health management team.

The satisfaction of the health management team with the supervisory activities increased significantly. In 1991, eight of the nine members interviewed said that preparation of supervision took account of supervisory objectives and targets in the light of evaluation and previous reports; they also indicated that a supervisory schedule was prepared and distributed to all health units. Six members reported that the entire health management team was involved in the preparation of supervisory activities; the other three stated that only some members were involved. In 1990, by contrast, most of the interviewed members had reported that only one or two members were involved in such work.

In both the urban and rural districts the health management teams can adopt the process of district action research and education without having to call on extra resources.

Seven members reported in 1991 that morning sessions were introduced but that attendance had been irregular and that for the last three months none had been held because of an outbreak of meningitis.
Six members reported that monthly meetings of the team had been resumed.

All the interviewed team members agreed that problems identified during supervision were recorded and that some of them were solved. In 1990, eight members said that

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**The plan for the rural district focused mainly on improving the preparation and follow-up of supervisory activities through a workshop, morning sessions, and monthly meetings involving members of the district health management team.**

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written feedback had been sent to all health units, and in 1991 all the interviewed members said that this was done. Seven members said that no quarterly or annual reports on supervisory activities had been prepared and that the first quarterly report was expected at the end of September 1991; two members were not aware of this.

The six heads of health units who were interviewed all reported that supervision was carried out by a team. All had received supervision schedules in advance and their units had been supervised three or more times during the preceding year. Five of the heads said that discussions with all health workers were held after supervision but one reported that only the head was involved. Some of the matters discussed during supervisory visits were:

- improvement of vaccination coverage;
- home visits;
- improvement of environmental sanitation;
- relationship between health workers and village leaders;
- uniforms and equipment;
- dispensary repairs;
- promotion of health workers;
- water shortages.

Four of the heads said that no written feedback was received after supervision. Five agreed that the supervision given was helpful because it made the health workers aware of the latest developments, gave access to the supervisory team, and helped to improve health care delivery. One head thought that supervision was not helpful because of a lack of feedback. The heads suggested the following improvements:

- supervision should be conducted early during working hours;
- written feedback should be sent to health units;
- more seminars should be conducted by supervisors;
- supervision should be conducted by senior personnel;
- spare parts for bicycles should be supplied to health units.

The working group made the following suggestions, on the basis of which a plan of action for a year was developed.

- The preparation and follow-up of supervision should be improved.
- The knowledge and skills of the heads of all health units on supervision should be improved.
- Opportunities for continuing education should be increased by strengthening discussion classes in health units, holding discussions after supervisory visits, and distributing health learning materials.
• Libraries should be established in two health centres.

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In the urban district of Dodoma the increased job satisfaction of health workers is attributable to the implementation of the plan of action and to the special allowances that they received (4). The emphasis given to recognition, reward, and quality of supervision was helpful in improving motivation. The job satisfaction questionnaire was undoubtedly a sensitive tool for measuring changes in motivation.

Satisfaction declined slightly in relation to the degree to which the work done was found interesting, the competence of supervision, and the fixing of objectives by the workers themselves, all of which matters could be tackled locally; the health management team could, for example, produce written feedback on a regular basis and try to solve problems of peripheral staff seen during supervision. Equipment of inferior quality, low pay, poor housing and inadequate transport commonly affect motivation. Unfortunately, these problems cannot be solved by the district: the intervention of central government is needed.

Generally, the gap between the average satisfaction levels of peripheral and city health workers narrowed, possibly because of increased attention given by the health management team to the latter and their comparatively prompt access to allowances. The chronic problem of transport and the outbreak of meningitis in the district impeded regular supervision of the periphery.

The district library, although appreciated by health workers, was not fully utilized because the facilities were inadequate and there were few items in Swahili. Continuing education could have been enhanced if supervisory visits had not been restricted due to transport problems and the outbreak of meningitis. Distance education was not started because of the absence of guidelines, a programme and learning materials. However, these are now available.

In the rural district of Dodoma there was, in general, a marked improvement in supervisory activities. The health management team workshop contributed greatly in bringing the members together in joint endeavour. Although the team members said that written feedback was sent to all supervised health units, four of the six heads of units disclosed that they did not receive them. The sending of feedback on supervision to health facilities can help it to become more caring and supportive and should not, therefore, be neglected.

Further increases in the motivation of health workers could be realized with strong involvement of central government, especially in respect of pay, fringe benefits, transport and housing.

The suggestions given by the heads of health units underlined the need for continuing education. Access by health staff to health learning materials and senior colleagues is minimal at the periphery, and so it is necessary to devise methods for updating the knowledge and skills of peripheral health workers in the interest of motivation (5, 6).

In both the urban and rural districts the health management teams can adopt the process of district action research and education without having to call on extra
resources. However, Tanzania’s Ministry of Health is implementing the process through district primary health care committees (7), and the outcome of both approaches should be evaluated.

Although there was some improvement in planned activities, it was not possible to achieve an overall advance in the health delivery system in a year. Further increases in the motivation of health workers could be realized with strong involvement of central government, especially in respect of pay, fringe benefits, transport and housing. Nevertheless, by using the process of district action research and education, both of the district health management teams strengthened their capacities and developed positive problem-solving attitudes.

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References