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Tackling obstacles to health care delivery at district level

In Tanzania's Dodoma Region a process was adopted for identifying problems of health care delivery which might be solved at district level by means of existing resources.

In 1980 Tanzania instituted a programme to make health care accessible to all its 10 million people. Today at least 70% of the population live within five kilometres of a health centre or village health post.

Although coverage is high the quality of care is variable. It might be argued that further improvement requires increased funding but much could be accomplished by making optimal use of the human and fiscal resources already available. We have used the district action research and education process, developed by WHO *(1)*, to identify problems that might be solved at district level by means of existing resources. A study was conducted in the urban and rural districts of Dodoma Region, which has a population of about 1.25 million. In the urban district there are two hospitals, two health centres and 23 dispensaries employing a total of 562 health workers; the rural district has a hospital, six health centres and 54 dispensaries employing 676 such workers. Each district is supervised by a health management team consisting of a district medical officer and the heads of services.

Working groups were convened which each consisted of the district health management team, a local government representative, three peripheral health workers and three community members. The peripheral health workers and community representatives were selected by the district health management teams. The process was easier in the urban district because of its small extent and because selected workers could attend the meetings and return home each night without being paid overnight expenses. In the rural district there were administrative and logistical constraints, and two medical aides who were attending a refresher course in the regional hospital represented the peripheral health workers. In the selection of the community representatives, members of health committees were chosen who were aware of the problems in their districts. After the groups were nominated, two days of

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discussions were held to explain the district action research and education process. All sessions were held in Swahili. The working groups of the two districts functioned separately.

The nominal group technique was used for the identification of the health management problems *(2)*. Their ranking was decided by the groups on the basis of a scoring system. The problem with the top score in each district was chosen for further evaluation, and its possible underlying causes were discussed.

Further analysis of the selected problems involved rapid appraisal and quick surveys using simple questionnaires. For the problem of low motivation in the urban district a job satisfaction questionnaire, developed by WHO, was modified for local use *(3)*. For the rural district a questionnaire was developed which took account of the locally identified causes of poor supervision. Both questionnaires were translated into Swahili and pretested on staff members from the urban and rural districts who were not subsequently involved in the survey.

In the urban district, data were collected from both staff and supervisors in six of the dispensaries and the two health centres.

The urban district's management team identified low staff motivation as the main problem limiting the quality of health care.

These sites were chosen following supervisory visits made by the district health management team, which took into consideration the geographical distribution of the units. Everyone on duty at each site was included in the study.

Table 1. Health management problems identified in the urban part of Dodoma Region

Problem	Number of members of working group identifying each problem (out of 15)
Low staff motivation	12
Poor transport	11
Poor supervision	10
Shortage of drugs	8
Poor continuing education	8
Lack of health education	5
Lack of community awareness on health	4
Poor equipment	4
Difficulties with culture and beliefs relating to health	4
Poor relationships between workers	3
Poor job descriptions	1
Unequal opportunities to attend seminars	1
Poor care of equipment	1
Poor accountability of work	1
Interference of politicians with working regulations	1
Excessive distance of health facilities from communities	1
Misuse of funds	1

In the rural district the selection of sites and staff followed the same pattern. The questionnaire was presented in three health centres and three dispensaries, and a check-list was used to assess the views of the health unit leaders on supervisory activities. Another check-list was employed for assessing the supervisory skills of the district health management team and obtaining a deeper understanding of the causes of poor supervision within it.

The working groups were given the results of the in-depth study of selected problems as analysed by smaller groups. A selection was made of those problems identified by the survey which the groups thought they could tackle within existing constraints. Solutions were suggested and a one-year plan of action was prepared for their implementation.

Urban problems

Seventeen health management problems were identified in the urban area (Table 1).

The group agreed through further discussion that the five most important health management problems were low staff motivation, lack of community awareness on health, poor supervision, poor equipment, and poor transport. Low staff motivation was selected as something that could be tackled using the resources in the district. The following underlying causes of the problem were identified.

- Lack of protective equipment
- Scarcity of working materials
- Lack of housing
- Unfair selection of seminar participants
- Poor transport
- Low pay
- Lack of supportive supervision
- Delayed payment of allowances and other monies
- Limited prospects of career development
- Lack of or delay in promotion
- Lack of appreciation of good work
- Lack of feedback
- Overwork due to staff shortages
- Hostility of villagers to health workers
- Lack of supportive attitudes from village leaders.

The job satisfaction questionnaire was completed by 73 health staff, of whom 9 were clinicians, 19 were trained nurses, 2 were health officer assistants, and 43 were supporting staff; 75% were women, about half were aged 30–39, 2.7% were over 50, and 70% were married.

The average score for job satisfaction was 2.4 on a scale of 1 to 4 (Table 2). In general the workers liked their jobs and were respected by the community, and patients appreciated their services. Moreover, the staff felt that they were contributing to the health care delivery system and were able to plan their work and apply their training. However, low scores were obtained in respect of fringe benefits, transport, housing, pay, equipment, reward and recognition for good performance, and prospects of promotion. Even so, the staff tended to be more motivated than was indicated by their supervisors in the areas of salary, pension, transport and housing. On the other hand, the staff seemed to be less satisfied than was indicated by their supervisors as regards prospects of continuing education, challenging work, and governmental support.

Table 2. Job satisfaction among urban health workers

Factor	Score[a]
Interest of work	3.6
Planning of own work	3.3
Responsibility for results of work	3.3
Application of training	3.2
Community respect	3.2
Colleagues' respect	3.1
Patients' appreciation	3.1
Competent supervision	3.0
Fixing of own objectives	3.0
Allocation of precise work objectives	2.8
Challenge of work	2.8
Job security	2.8
Caring supervision	2.6
Competent colleagues	2.6
Working conditions	2.6
Fair treatment by superiors	2.5
Safety at work	2.5
Government support	2.4
Setting of objectives by discussion	2.4
Information on work performance	2.3
Perceived value of work	2.3
Prospects of continuing education	2.1
Pension	1.9
Good equipment	1.8
Pay	1.8
Prospects of promotion	1.8
Reward and recognition for good performance	1.8
Housing	1.6
Transport	1.6
Fringe benefits	1.4

[a]4 = great satisfaction; 3 = some satisfaction; 2 = some dissatisfaction; 1 = great dissatisfaction.

Table 3. Health management problems identified in the rural part of Dodoma Region

Problem	Number of members of working group identifying each problem (out of 15)
Poor supervision	11
Poor transport	11
Low staff motivation	7
Inadequate equipment	5
Shortage of trained personnel	4
Lack of continuing education	3
Shortage of water at health units	3
Shortage of drugs	2
Delayed promotion	2
Lack of health facilities in remote villages	2
Inadequate health budget	1
Poor community participation	1

The most pressing causes of poor staff motivation, including inadequate salaries, pensions, fringe benefits, transport and housing, have to be tackled mainly at national level. Nevertheless, several issues, among them continuing education and the reward system, can be addressed at district level. It was decided to attempt to reduce dissatisfaction through actions requiring only the available resources. The prospects for continuing education, and the reward and feedback systems, were to be improved.

The solutions suggested were to:

— strengthen teamwork and staff management by the district health management team;

— establish a district library;

— introduce classes at all health units and hold discussions with staff during supervisory visits;

— improve recognition, reward and feedback systems;

— introduce a distance education programme for peripheral health staff.

Rural problems

Twelve problems were identified in the rural areas (Table 3).

The first five problems in Table 3 were selected as the most pressing. Poor supervision was considered the one that could be tackled using the resources available in the district.

The underlying causes of poor supervision were identified as follows.

- Poor transport
- Improper delegation of authority
- Poor preparation for supervision
- Lack of evaluation
- Poor supportive supervision
- Poor feedback
- Poor supervisory skills
- Low staff motivation
- Poor participation of community leaders
- Poor accountability and negligence of health workers
- Inadequate frequency of supervision
- Poor interpersonal relationships

The questionnaire on supervision was completed by 72 staff members, of whom 16 were clinicians, 9 were trained nurses, 5 were health officer assistants and 42 were supporting staff; 53% were aged 20–29 and 31% were 30–39; 64% were women.

The staff were highly satisfied with the supervision carried out by the district health management team (Table 4). Interpersonal relationships were very good and the relationship between health staff and village leaders was good. Most dissatisfaction concerned lack of incentives, inadequate equipment, and lack of transport.

The three health centres visited were supervised by the district health management team, and the three

dispensaries by members of the team and the medical assistant in charge of the nearest health centre. In three health centres and one dispensary the last supervision had taken place a month before the interview, while in the remaining two dispensaries it had been conducted two months before the interview. Three of the heads of health units had supervision schedules.

The average time for a supervisory visit to a health unit was about five hours. The supervisory team occasionally met all the staff in five health units. Only one of the health centre leaders supervised his satellite dispensaries; the other two said they could not do so because of a lack of transport. Of the three dispensary leaders interviewed, only one said he carried out home visits; another said he made monthly outreach visits to supervise village health workers; the third admitted that he did not supervise village health posts.

Table 4. Satisfaction with supervision among rural health workers

Factor	Score[a]
Fixing of own objectives	3.5
Interpersonal relationships among health staff	3.5
Competence of supervision	3.4
Relationships between supervisors and health staff	3.4
Time spent in health unit on supervision	3.4
Allocation of precise work objectives	3.2
Feedback after supervision	3.2
Preparation for supervisory visits	3.2
Relationships between village leaders and health facility leaders	3.2
Responsibility for own work	3.2
Supervision frequency	3.2
Possibility of setting objectives by discussion	3.1
Evaluation of supervision	2.9
Caring supervision	2.8
Quality of equipment	1.8
Transport	1.8
Incentives	1.7

[a]4 = great satisfaction; 3 = some satisfaction; 2 = some dissatisfaction; 1 = great dissatisfaction.

All six of the interviewed district health management team members said its last meeting had been four months previously. Five of the team members said the schedule for supervision was prepared by one or two members. One member said it was prepared by reviewing the previous schedule and discussing it with other members.

The principal demotivators, namely inadequate pay, fringe benefits, housing and transport, cannot be altered by the district authorities.

All the interviewed members said the supervisory team did not normally meet before conducting a supervision. Four said that the completed supervisory forms were filed. A record was kept in an exercise book of problems that were identified, although only urgent ones were discussed. Two members did not know what happened to the completed forms.

Five team members said feedback to the staff of supervised health units was given in written form or, occasionally, verbally when another visit was made. One team member said no feedback was given. Half of the members complained of unfair treatment with respect to fringe benefits.

All the interviewed team members felt that transport was adequate between the district and the peripheral health units but that this was not the case between the peripheral units and their catchment areas.

It was clear that supervision was not a problem at peripheral health units. However, it was a major problem at the level of the management team. With a view

to strengthening the team and improving supervision it was suggested that steps be taken to:

- consolidate teamwork among members of the district health management team;
- ensure that a monthly meeting of the team be held;
- identify the team members responsible for supervision and give them job descriptions;
- nominate a team secretariat to prepare a schedule;
- introduce morning sessions of the team during which, among other things, supervision could be discussed;
- ensure completion of reports after supervision and of quarterly reports on supervisory activities;
- send written feedback to health units in an agreed format the day after supervision, following discussion by the supervisory team.

* * *

The research was intended to assist the district health management teams in identifying managerial problems affecting health care delivery, to identify their causes, and study the problems further. The working groups were small in both districts and were not altogether randomly selected. The health workers who completed the questionnaires were too few to be representative of all those in the districts. Nevertheless, useful information was collected in a relatively short time and it helped the district health management teams to devise solutions.

The supervisors' response was to a large extent the same as that of the supervised health workers.

In the urban district the perceptions of the working group were confirmed by the survey of health workers. In the rural district, however, the corresponding survey findings did not verify the assumptions of the working group. This emphasizes the importance of carefully selecting individuals for focus groups and the need for in-depth studies of selected problems.

The urban district's management team identified low staff motivation as the main problem limiting the quality of health care. The principal causes of low motivation were poor fringe benefits and low pay, which did not allow the health workers to satisfy their most basic needs. This is hardly surprising, given the difficult economic conditions in many developing countries at present. The supervisors' response was to a large extent the same as that of the supervised health workers. A questionnaire with more specific questions for each of the two groups might have shed more light on the supervisors' views.

In the rural district the health workers were satisfied with the supervision. Although this may have stemmed from the lack of representativeness of the rural working group, it could also have arisen because the group was out of touch with reality as regards supervision, or because the health workers were unfamiliar with proper supervision. In the latter event, the district health management team was possibly correct in identifying supervision as a problem. This is supported by the findings of a Ministry of Health evaluation team which related the decline of immunization coverage in the district to

poor supervision *(4)*. Supervisory problems even existed in the team itself.

In both districts, it would be possible to tackle many of the demotivating factors at district level. However, the principal demotivators, namely inadequate fringe benefits, housing and transport, cannot be altered by the district authorities. The Ministry of Health recently started a programme aimed principally at motivating health staff. Health workers whose advancement was delayed are now being promoted; to raise the incomes of health workers, various types of allowance have been introduced.

Clearly, much can be done using existing resources to improve the quality of health care. We hope the districts will implement the plan they developed and that the experience will be beneficial to other districts throughout the country. □

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Hesitation = inaction

While the personal, community and global benefits of effective AIDS education are generally acknowledged, the fear of addressing such a sensitive issue sometimes results in failure to act.

— Graham Collier & Kevin Donnelly, in *AIDS prevention through health promotion: facing sensitive issues.* Geneva, World Health Organization, 1991, p. 73.