HEALTH SERVICES DELIVERED BY THE BUKOBA MUNICIPAL COUNCIL: WHAT HAS QUALITY GOT TO DO WITH IT?

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51 Uporoto Street (Off Ali Hassan Mwinyi Road), Ursino Estate
P.O. Box 31226
Dar es Salaam, Tanzania.
Tel: (+255) 22 2760260, 2760751/52
Mobile: (+255) 754 280133
Fax: (+255) 22 2760062
Email: esrf@esrf.or.tz
Website: www.esrftz.org

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ABSTRACT

The study set out to investigate quality service delivery in local authorities, using Bukoba Municipal Council (BMC), as a case study with particular interest in the health sector. The specific objectives were to determine if health services users as well as those that work in them were satisfied with the quality of the health services delivered by BMC and also to identify possible obstacles that hinder BMC from rendering satisfactory quality health services. The findings of the study revealed that users and health staff were not satisfied with the quality of health services delivered. The delivery of quality health services was hampered by obstacles related to technical competence, access to service, affordability, interpersonal relations between clients and health staff, reliability of the services and amenities. The study concluded by noting that BMC's delivery of health quality service is unsatisfactory and needs improvement on many fronts, as improved health quality service leads to increased productivity, educational performance, life expectancy, savings and investments, and decreased debts and expenditure on health care.

1.0 INTRODUCTION

1.1 Background Information

As a consequence of considerable dissatisfaction with the results of centralised economic planning, socio-economic reformers have turned to decentralisation to break the grip of central government and to induce broader participation in democratic governance (Olowu 2000; World Bank 1999; Manor 1999). Being closer to the people, it is claimed that local authorities can more easily identify people's needs, and thus supply the appropriate form and level of public services (Crook & Manor 1998; Oates 1972).

The local government system in Tanzania has had a long and chequered history. The early forms of local self-government were based on chiefdoms and sub-chiefdoms, and following colonisation, the British local government model was adopted. In the post-colonial era the local government system, was starved of resources. Hence it was unable to deliver adequate services to the people (Warioba, 1999).

In 1972, local governments were abolished in favour of a more centralized system of government. Central government and line ministries were put in charge of the administration of basic government services at the local level, including primary education and health care. However, the delivery of public services actually deteriorated under this system of deconcentration, and local governments were re-introduced by the 1982 Local Government Acts No 7 and 8 (URT 1982a, URT 1982b).

While Local Government Authorities (LGAs) were technically reintroduced in mainland Tanzania in 1984, the system was a top-down modality and local governments were tightly constrained by central government bureaucracy. In addition, local government had lost many of its senior management and technical staff. Central government ministries, through their regional administrative offices, were delegated strong powers to continue to direct almost all aspects of the affairs of local government (Max, 1991). However, this system also failed to yield the desired improvements in the delivery of local services, while stifling local democracy, and by the early 1990s it had become evident that fundamental reform of the system was imperative (ibid).

During the early 1990s, a comprehensive Civil Service Reform Program was launched, consisting of six components, including a Local Government Reform component. This component was aimed at decentralising government functions, responsibilities and resources to LGAs and strengthening the capacity of local authorities. Reform of the local government system was effectively initiated in 1996 through a National Conference seeking to move "Towards a Shared Vision for Local Government in Tanzania." This vision was subsequently

summarized in the Local Government Reform Agenda, and, in October 1998, was endorsed by the Government in its *Policy Paper on Local Government Reform (URT, 1998)*. The Government's vision is to have a local government system in which LGAs are (ibid):

- Largely autonomous institutions, free to make policy and operational decisions consistent with the laws of the land and government policies;
- Strong and effective institutions underpinned by possession of resources (both human and financial) and authority to perform their roles and functions;
- Institutions with leaders who are elected in a fully democratic process;
- Institutions which will facilitate participation of the people in planning and executing their development plans and foster partnerships with civic groups;
- Institutions with roles and functions that will correspond to the demands for their services; and
- Institutions which operate in a transparent and accountable manner.

Therefore, Local government reform was expected to help LGAs to significantly improve their performance, to stimulate local economic development, and to deliver better quality services, especially in the pro-poor sectors such as health, education, roads, water and agriculture.

Despite efforts undertaken by the government to implement various programs in local authorities in order to improve quality service delivery, there are still many local authorities that are blamed by users for providing poor social services. This embraces even those authorities which have already completed the core Local Government Reform Program (LGRP). Hence this raises the question, are the reform at local level working to ensure that the users get quality service?

1.2 Statement of the Problem

Despite the local government reforms which were deliberately designed to improve LGA performance, the deterioration of public services combined with extensive poor delivery is still continuing in many local authorities in Tanzania.

With respect to the health sector in Tanzania, health services delivery does not yet meet the minimum standard of quality services (URT, 2008), suggesting that there is still some work to be done before the country can claim that it has achieved its Millennium Development Goals. These were amply reflected in the National Strategy for Growth and Reduction of Poverty (in Kiswahili: MKUKUTA), the National Health Policy (2007), 2009-2015 Health Sector Strategic Plan III, 2007-2017 Primary Health Services Development

Program, to name just a few examples (URT 2005, URT 2007a, URT 2007b, URT 2008, URT 2010).

In the context of the current paper, an extensive literature search revealed a research conducted by Braathen and Mwambe (2007) on *"Service Delivery in Tanzania: Findings from six councils 2000-2003"*. The manuscript detailed findings based on citizen's perceptions of performance and changes in services delivery in the six councils that were brought by the Local Government Reform. The paper concluded by pointing out that, the citizens were dissatisfied with the delivery of public service under local government reform program. Regrettably, among the six councils, Bukoba Municipal Council (BMC) was not included[1].

The extensive literature search for the current paper did not come across any previous studies that investigate the quality of health service delivery in BMC. Therefore, there is a critical need to fill this gap by increasing health sector knowledge and improving understanding of why quality matters.

1.3 Study Objectives

The broad objective of this study was to investigate quality service delivery in local authorities, using Bukoba Municipal Council (BMC) as a case study with particular attention to the health sector.

The specific objectives were:

- To determine if users and workers of health service providers are satisfied with the quality of health services delivered by BMC.
- To identify possible obstacles that hinder the BMC from rendering satisfactory quality health services
- Based on the information gathered, draw conclusion and make some policy recommendations for quality health services delivery.

2.0 CONCEPTUAL FRAMEWORK

According to the 2009-2015 Health Sector Strategic Plan III, quality in health services means working according to specific standards, which aim at improving the health status of individuals and communities, reducing suffering due to diseases and illnesses, and increasing clients' satisfaction. At the same time effectiveness and efficiency is increased (URT, 2008).

[1] The six local councils were Illala Municipal, Mwanza City, Iringa District, Bagamoyo District, Kilosa District and Moshi District

In the opinion of Edvardsson (1998) the concept of service quality should be approached from the customer's perspective. It is the customer's perception of service quality and it is he or she who determines the level of satisfaction. Meeting with the needs and expectations of the customer means that we know what the customer wants, we know what the customer expects and we can deliver them on a consistent basis. The customer is the best judge of the quality of service, not the service provider, regardless of how well organised the service provider's records seem to be.

Parasurman, Zeithaml and Berry (1988) proposed five dimensions or factors affecting service quality, namely: (i) Tangibles that include the physical appearance of the service facility, the equipment, the service personnel and the communication materials; (ii) Reliability in which service reliability differs from product reliability, in that the former relates to the ability of the service provider to deliver the promised service dependably and accurately; (iii) Responsiveness which is the willingness of the service provider to be helpful and prompt in providing service; (iv) Assurance that refers to the knowledge and courtesy of employees and their ability to inspire trust and confidence and (v) Empathy that is the customer longs for compassion , caring and individualised attention from the service provider.

With respect to health services, Brown *et al* (1991) who drew insights from Parasurman *et al* (1998), developed six distinct dimensions to better understand healthcare customers' perceptions of service quality. These dimensions are described in Table 2.1.

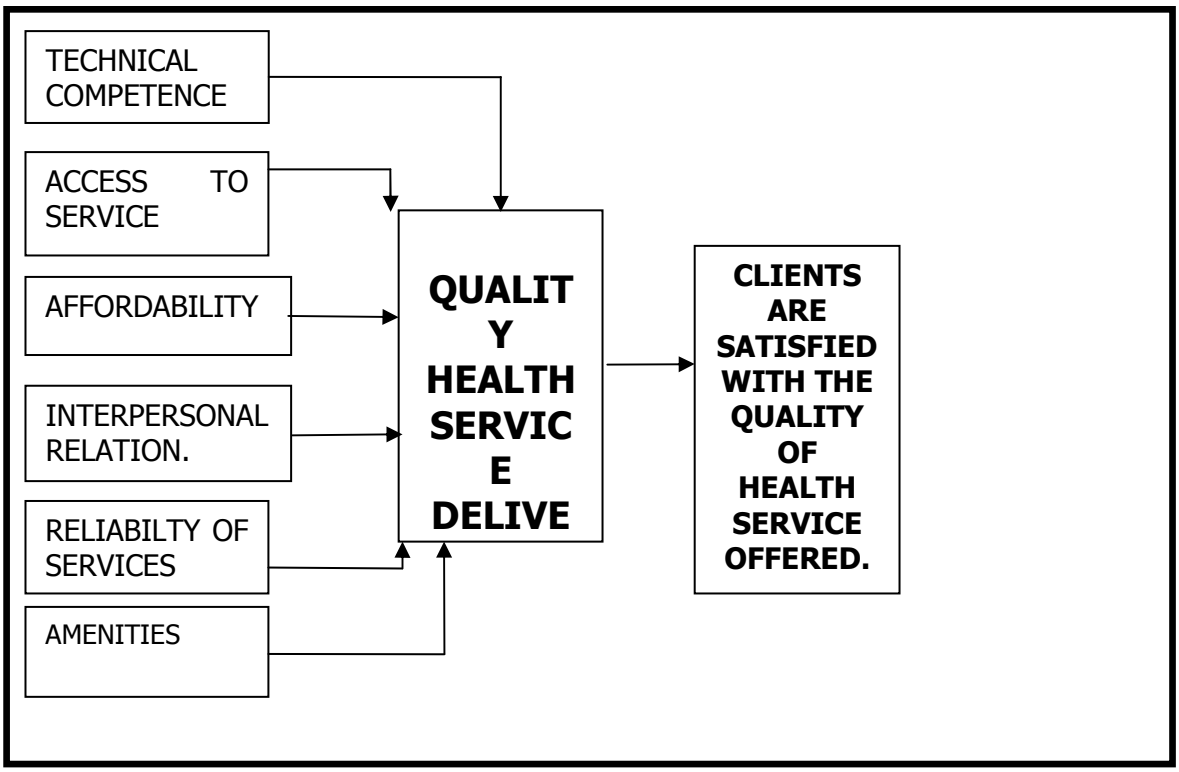
Table 2.1 Dimensions of Health Quality service

DIMENSIONS	DETAILS/EXAMPLES
TECHNICAL COMPETENCE	The degree to which health care personnel have the training and abilities to assess, treat and communicate with clients
ACCESS TO SERVICE	Being accessible and easy to contact, in term of distance from place of residence, and availability of service.
AFFORDABILITY	Service affordability in term of client's ability to pay for service rendered by (BMC) health facilities. Affordable service provides the greatest benefit within the resources available.
INTERPERSONAL RELATION (COURTESY)	Good interpersonal relations establish trust and credibility through demonstrations of respect, politeness, confidentiality, courtesy, responsiveness, and empathy.
CONTINUITY (RELIABILITY).	Client receives the complete range of health services that he or she needs, without interruption, cessation, or unnecessary repetition of diagnosis or treatment. Services must be offered on an ongoing basis and near to the place of residence.
AMENITIES (TANGIBILITY)	Relates to the physical appearance of facilities, availability of personnel, and materials; as well as to comfort, cleanliness, and privacy.

Source: adapted from Brown, et.al, 1991.

The relevance of the above health quality elements, that have been reflected in various health sector initiatives in Tanzania , is captured in the conceptual framework depicted in Figure 2.1. The diagram suggests that quality dimensions affect positively or negatively the delivery of health services.

Figure 2.1 Health quality dimensions relationship (Conceptual framework)



Source: Designed & compiled by the authors.

N.B: The dashed arrow underscores the importance of the courtesy of medical staff on the psychological feeling of the patient particularly in an environment where the services are deficient.

3.0 METHODOLOGY

This research study was conducted in Bukoba Municipal Council, Bukoba District, in Kagera region. Between November 2008 and January 2009, two health centres and five dispensaries were under intensive study in seven wards out of fourteen wards forming the municipality2. The Council was chosen to represent Local authorities in the country.

A convenience sampling method was used for administration of the questionnaire. 100 patients and 40 health staff (nurses, clinical officers, laboratory technician and medical assistants) who were asked to participate in the study completed the questionnaire.

Data collection methods included questionnaires, personal interviews, photography, personal inspections and observations in health facilities. Secondary data (obtained through library study, articles, patient's attendance registers, BMC reports to name just a few examples) was assessed for relevance and carefully read by the authors.

Quotations are included in the presentation of the data to give the reader the key informant's perception and lines of thinking in terms of their interpretation of the quality of Tanzanian health service delivery3.

2 According to the 2008 BMC annual report, seven wards out of fourteen wards health facilities in Bukoba Municipal Council. The wards include Rwamishenye ward with Rwamishenye Health Center, Bilele ward with Zamzam Health center, Kashai ward with Kashai Dispensary, Kitendaguro ward with Kagemu Dispensary, Ijuganyondo ward with Ijuganyondo Dispensary, Kahororo ward with Kahororo dispensary, and Buhembe ward with Buhembe dispensary. Other wards are Kibeta, Kagondo, Nyanga, Nshambya, Miembeni, Hamugembe and Bakoba; their citizens seek public medical services from a health facility located in a nearby ward, or sometimes from Kagera regional Hospital which is located at the center of Bukoba municipality. Investigated health Centers include: Rwamishenyi Health Center, Zamzam Health Center). Investigated dispensaries include : Kahororo dispensary, Buhembe Dispensary, Ijuganyondo Dispensary, Kashai Dispensary, and Kagemu Dispensary.

3 In interpreting the data we also draw on the additional insights that we gained during the interviews as well informal and formal discussions with Municipal Director, Municipal Medical Officer, Municipal Health Officer, Municipal Nursing Officer, and Medical Officer in-charge of health centre and dispensaries.

4.0 FINDINGS AND DISCUSSION

4.1 Number and Types of Health Facilities in Bukoba Municipality

As indicated in Tables 4.1 and 4.2 taken from the Municipal Health department reports, there are health facilities which are run by the central government, BMC and by private sector operators.

Table 4.1 Number and type of health facilities owned by central government and Private sector within Bukoba Municipality

Health Facility	Number	Ownership		Number of beds
		Central government	Private	
Hospital	1	1	0	250
Health centre	2	0	2	10
Dispensaries	7	1	6	0
Drugs/Chemists	3	0	3	N/A
Medical stores	34	0	34	N/A

Source: Municipal Health department report, 2007.

Table 4.2 Number and type of health facilities Owned by Bukoba Municipal Council

Health Facility	Available	Ownership	Required
Municipal/District Hospital	0	BMC	1
Health centre	2	BMC	4
Dispensaries	5	BMC	14
Drugs/Chemists	0	BMC	N/A
Medical stores	0	BMC	N/A

Source: Municipal Health department report, 2008.

Interestingly, the Bukoba Municipal council had two health centers and five dispensaries. It did not have its own Municipal/District Hospital. Many of its patients who are referred from Health centres were directly attended by the Kagera regional Hospital which is located within Bukoba municipality4. The municipal council director remarked:

> *"The BMC is expecting to have its own district hospital by year 2010 because the following efforts have been reached in order to make sure the hospital is built. Firstly, the finance and management committee of the council has approved the*

4 Municipal Health Department report, 2008

process of building the hospital. Secondly, the location for building that hospital has been secured at Nshambya ward. Thirdly, the architectural survey and architectural drawings will be complete by 5th February, 2009. Lastly, initial building cost estimates of the hospital are about Tanzania shillings eight hundred million only5"

The BMC health department did not also have a full-fledged medical doctor. It was manned by an assistant medical officer (AMO), clinical officers, nurses, laboratory assistants, and medical attendants. The district medical officer was an assistant medical officer and not a medical officer as required by the public service scheme.

The health indicators in Bukoba Municipality are shown in Table 4.3.

Table 4.3 Municipal Health indicators

No.	Indicator	Bukoba Municipality Rate/percentage	Tanzania Mainland Rate/percentage
1.	Maternal mortality rate	640/100,000	578/100,000
2.	Infant mortality rate in health facilities	51/1,000	58/1000
3.	Under five mortality rate	36/1,000	94/1000
4.	Immunization coverage for under 1 year children	90%	N/A
5.	Number of malaria cases (OPD)	59%	N/A
6.	HIV/AIDS	6%	7%

Source: Municipal Health department report, 2008 and URT(2007).

4.2 Satisfaction with the quality health services offered by the Council

Generally, the findings indicated that in a sample of 100 patients who were found in health facilities, 63% expressed dissatisfaction with health care services, 26% were satisfied and in the opinion of 10% of interviewed respondents the delivery of BMC health services were average.

Patients genuinely recommended improvements in the following areas : working conditions (3 respondents); increase of staff and drugs/medicines (61 respondents); training of health staff to serve better and politely patients (1 respondent); reliable laboratory service in their health facilities (1 respondent); health facilities to work 24 hours including weekends and public holidays (8 respondents); and reliable health services (25 respondents).

5 Interview, Mr. Shaibu N'nunduma, BMC director, BMC head quarter; 05th December, 2008.

On the part of service providers, there were comments regarding the motivation of health staff in delivering services. To be more specific, 21 out of 40 staff pointed out that there was poor motivation. 17 respondents mentioned that motivation was average and in the opinion of 1 respondent, there was high employee motivation.

4.3 Access to service

Poor accessibility of health services in Bukoba municipality was manifested through long queues and waiting hours because dispensaries and health centres did not have enough health care workers to attend to patients immediately, as seen in Figures 4.1, 4.2 and 4.3 and elaborated below:

On 29th December, 2008 at Kashai Dispensary there were about sixty patients served by just one nurse and one medical attendant6. There was no clinical officer at the dispensary that day. Due to few medical staff attending a large number of patients, one patient (a pregnant woman) fainted in a queue. An expecting mother lamented:

> *"We are here for more than five hours and there is no one to attend us. There is just one nurse attending us and there are many other women who came for family planning health services, contributing to the long queue times ".7*

On 11th December, 2008 at Zamzam Health Center, one clinical officer pointed out:

> *"It is too difficult to deliver a quality service with the shortage of staff. It is difficult to concentrate on one patient knowing that there is large queue of 100 patients waiting outside the facility to be attended by the same clinical officer"8*

6 Observation, Kashai dispensary, 29 December, 2008
7 Interview, Neema Habibu, pregnant woman, Kashai Dispensary, 29 December, 2008
8 Interview, Mr. John Nchobe: clinical officer, Zamzam Health Center, 4th November, 2008.

Figure 4.1 Zamzam Health Center.

Figure 4.2: Buhembe Dispensary

Figure 4.3 Kashai Dispensary

Patient -completed questionnaires revealed that 70% spent a time ranging from 30 minutes to three hours before they receive a service in the health facilities of BMC contrary to hours they spend in the private hospital9. However, 27% spent 20 minutes to one hour before they were attended and 2% mentioned that the time spent in the health facility was less than 20 minutes.

4.4 Interpersonal Relation

An administered questionnaire which asked if patients were fairly treated by the health personnel indicated: 78% of respondents were satisfied with their attitudes. However, 13% complained that clinical officers' attitudes towards patients were unpleasant and dismissive. Clinical officers did not give clear answers as to the patients' disease status.

At Rwamishenye Health center, one patient expressed:

> *"I was one day late for my child's appointment because of a personal problem. When I met the nurse, she got annoyed and rejected to attend me. She insisted that I visit the facility next Friday. When I asked if I will be able to a get service on that day, she replied that, I will know myself whether there will be a service or not. I was so disappointed as the nurse did not care about me" 10*

9 Comparison made by patients of RHC, ZHC, Buhembe, Kagemu, Kahororo, Ijuganyondo, and Kashai Dispensary: names withheld; November -December, 2008.

10 Interview, patient, Mrs Patricia Rugambwa; Rwamishenye Health center: 2nd December, 2008.

At ZamZAm Health Centre, one patient confronted a nurse about the long waiting time. The nurse replied:

> *"You should continue waiting if you want to be treated, and if you see waiting in a queue as a problem, you can quit or go to private hospitals if you want a quick service"* 11

In the opinion of one nurse, an employee's bad attitude is

> *" ....Caused by staff shortage. One medical staff may have more than 100 patients a day. We are human beings who get tired and this many times causes arguments with clients. In our minds we think we are providing service . It is better to employ more staff for better service delivery in health facilities" 12*

4.5 Reliability of Health Services

The 100 completed questionnaires indicated that, 84% of patients found health service reliable against 16% of respondents who felt the opposite. The unreliability of health services is discussed in the following paragraphs

Firstly, it was observed that, Zamzam and Rwamishenye health centres and the five dispensaries under study did not operate on weekends and were closed at 16 hours from Monday to Friday13. In investigating whether this was a common practice, the officer in-charge of Rwamishenye Health Center explicitly stated:

> *"Due to shortage of staff and lack of staff accommodation in all BMC health facilities, it becomes difficult to rotate staff on weekends and night hours. This exercise is possible only when facilities have enough staff or the council is able to pay staff to work overtime" 14*

Moreover, on 25th December and 26th December, 2008 there were five patients unnecessarily stranded at Zamzam and Rwamishenye health centres. One of the patient lamented:

> *"we are aware that hospitals do not close on a public holiday, but BMC's health facilities are closed daily at 16 hours and they do not open on weekends and public holidays. Bad enough, they do not open during the night. For emergencies, we*

11 Interview, name withheld, nursing officer, ZHC: 4th November, 2008.
12Interview, Haulat Hassan, a nurse, Kashai Dispensary Bukoba Municipality: 20 November, 2008.
13 Interview, clinical officers, names withheld, ZHC and RHC: 4th -5th November, 2008.
14 Interview, Mr.Verus Kweyamba, Officer In-charge, RHC; 12th December, 2008.

normally go to the regional hospital or to private health centres to access health service".

Secondly, the lack of electricity in health centers and clinics contribute to poor and unreliable health services. On 12th December, 2008, a visit at Rwamishenye Health Center revealed that it had no electricity for almost three weeks, suggesting that the laboratory service was not accessible. When the Laboratory assistant was asked why the facility was out of electricity, she answered:

"The responsible officers are reluctant to pay the electricity bill that is why we don't have power supply. Our laboratory does not provide services if we don't have power supply. With this situation patients have no choice but to go to a private laboratory to get a paid service which is difficult to afford for most of them."15

Thirdly, on 3rd December, 2008 it was observed that at the laboratory of Buhembe Dispensary, laboratory personnel was not present to see patients. Meanwhile, outside patients were complaining that the clinical officer administered medicine without relying on laboratory examinations. One patient complained that:

"we have been coming and finding the laboratory closed as the laboratory assistant is away for training. As a result we fail to get laboratory services. It is in our opinion that, there should be two laboratory staff in the event that one of them is away". 16

Fourthly, in the opinion of interviewed medical personnel, a shortage of staff in all health facilities of BMC was cited by 43% as a major cause of poor reliability of health service. 53% of interviewed medical personnel were neutral about the shortage of staff. 4% said that there was no problem of staff shortage.

Fifthly, the lack of prescribed medicines at BMC's health facilities' pharmacy (for an example of a pharmacy see Figure 4.4) also contribute to poor reliability of health services. This was indicated by 84% of patients. On the other hand, 15% stated that medicines were available at the pharmacy and 1% of respondents were indifferent. Furthermore, in the opinion 10% of interviewed medical staff, BMC health facilities' pharmacy kept a variety of medicines. 55% of respondents reported that the variety of medicines kept in the pharmacy was average and 33% of respondents were opined that there was a low variety of medicines kept in BMC's health facilities' pharmacy.

15 Interview, Laboratory Assistant, name withheld, RHC, 18th November, 2008
16 Interview, Patient, name withheld, Buhembe dispensary, 3rd December, 2008.

Figure 4.4 A Pharmacy and a nurse acting as the Pharmacy technician at a Health Center

Lastly and on the same related note, patients rarely obtained the prescribed medicine and were thus referred to private medical stores that were owned by the medical staff of the studied health facilities. One patient discerned this point:

> *"patients are normally told to buy medicine from a private medical store, as the dispensary [Kashai Dispensary] is always out of medicine and we have discovered that, most of these stores are owned by the staff from the dispensary as they are seen selling in those shops after normal working hours."*

This raises the question of whether medical staff were using the patients' predicament and the artificial scarcity of medicines in the public health facilities to make more money privately.

4.6 Affordability

BMC like any other council in Tanzania introduced user fees to its health facilities. Patients paid five hundred Tanzania shillings (500/=) to access service.

Officially under five children, pregnant women and elderly patients were exempted to pay for health services. The study found out these patients were sometimes charged to access health services.

All interviewed patients stated that the user fee to access health facilities was fair. However, one patient remarked:

"The fee is fair, but the problem comes when the facility is not equipped with medicines and a laboratory service. This means that we are required to go to a private pharmacy to buy medicines or to a private laboratory for medical examinations. Poor patients have limited funds to consume private services. In this regard, we advise the municipal council to equip their health facilities with laboratory service and medicines17."

There is overwhelming evidence in the literature on the negative consequences of user fees in public health facilities (e.g. Morestin and Ridde, 2009). The limitation in revenue generating potential and adverse consequences of applying the fees were elaborated by the officer in-charge of Rwamishenye Health Center:

The user fee of Tanzania shillings five hundred is insufficient if we want to improve the quality of health service. The same amount caters for all services patients deserve at the health facility. These include laboratory service, medicines and consultation service. That is why in many of our health facilities we lack things like variety of medicines, and reagents in our laboratory compared to private health facilities where patients pay significant amount to access the service.18

4.7 Technical Competence

The study at BMC which visited two health centres and five dispensaries found that, these facilities were manned by few staff and most of them were not fully trained with respect to the work they are performing.

In all seven health facilities there were no qualified pharmacy technician or assistant to supply medicines to patients. Instead medical attendants were doing this job. A medical attendant at Kagemu dispensary claimed:

I have no formal skills but I'm just using experience to do my job. We are very few staff at this facility and there is no one to do this job. I hope I will get training in the future with respect to this job19.

At Kahororo and Ijuganyondo dispensaries there were no qualified doctors or clinical officers to attend patients. Instead the job was assigned to nurses who were not competent and comfortable in performing such duties. One nurse at Ijuganyondo dispensary confirmed:

17 Interview, name withheld: patient, RHC, 12th December, 2008

18 Interview, Mr. Verus Kweyamba; In-charge; RHC: 12th December, 2008.

19 Interview, name withheld, medical attendant, Kagemu dispensary: 12th December, 2008.

"I have had no training as a medical doctor, so why should I perform this type of clinical job for which I have no competencies and which is also against medical ethics?. To make matters worse, I was never issued a formal letter to perform such a job but it was instead orally assigned to me. So if there are problems, I am afraid to be held responsible20"

The use of unqualified staff according to interviewed medical staff and patients and amply corroborated by the literature could lead to poor drug prescriptions which may cause danger or complications to patients . This suggests unnecessary or inappropriate care mainly produces harms and few benefits if any.

Despite serving an average of 792 patients per month as shown in Table 4.4, Kagemu Dispensary had one clinical officer, two nurses and two medical attendants. In addition, the health facility did not have any laboratory and assistant pharmacists. Should the clinical officer be on an annual leave, training leave or attending a health seminar somewhere, patients will have no choice but to be treated by a nurse. This had been a normal practice of the day for heath facilities in BMC.

Table 4.3: Trend in Patient Numbers Against Medical Staffing at Kagemu Dispensary in 2008

	Jan	Feb	March	Apr	May	June	July	Aug	Sep	Oct	Nov
Patients	537	600	498	836	673	967	873	856	884	1105	881
Clinical Officers	1	1	1	1	1	1	1	1	1	1	1
Nurses	2	2	2	2	2	2	2	2	2	2	2
Lab. Tech	0	0	0	0	0	0	0	0	0	0	0
Pharmacist Asst	0	0	0	0	0	0	0	0	0	0	0
Medical Attendant	2	2	2	2	2	2	2	2	2	2	2

Source: *Kagemu Dispensary monthly health report, 2008.*

4.8 Amenities

The study revealed that working conditions were poor as mentioned by 52.5% of 40 health staff. 37.5% of the same reported that the working condition was average, and according to 7.5% respondents the working conditions of BMC's health facilities were good.

The study further revealed that all seven health facilities in BMC suffered from inadequate working space for providing quality service. For example, in Kashai dispensary, it was observed that there was one room used for attending pregnant women and other women

20 Interview, Mrs. Jovina C. Tibamanya, nurse midwife, Ijuganyondo dispensary: 2nd January, 2009.

who sought family planning health care. In the event of an emergency, one nurse at Kagemu dispensary commented:

> *It is too difficult to attend emergency cases of women who go into labour at our dispensary because we do not have equipments and a delivery room for that purpose. We normally bear all risks associated and use our experience to serve both mother and child. We cannot chase her away on the pretext that we do not have equipments and a delivery room.21*

In Ijuganyondo dispensary, it was observed that the facility did not have enough chairs and tables for health staff. In addition, all seven health facilities did not have staff quarters; hence health staff travelled long distances to the workplace daily and could not perform their duties during night time.

The study also investigated the status of working equipments. The results of the questionnaire which were distributed to 40 health staff in seven health facilities of BMCl indicated that, 63% of respondents commented that modern technology and equipments availability was average (medium), 23% of respondents reported that, modern technology and equipments availability was low in their health facilities and 10% of respondents believed that BMC's health facilities were equipped with modern technology and equipments for providing quality health services.

Health facilities at BMC were faced with shortage of working equipments especially for laboratory services. For instance, as seen below (Figure 4.5), a laboratory assistant of ZamZam Health Center used a traditional way of examining specimen which can impair the reliability of clinical tests.

21 Interview, name with held; nurse midwife; Kagemu Dispensary: 15th December, 2008.

Figure 4.5: A Laboratory Examination

Laboratory staff revealed that essential equipments like hot air oven, sterilizer, centrifuge machine and fume chamber (safety cabinet) were not available in their laboratory. Hence, it became difficult to undertake intensive laboratory examination on their clients.

The study also found that there was an issue related to the types of weighing scale used on babies and children. The qualities to consider in these scales were safety, precision and durability.

Babies and children at Rwamishenye Health Center, Zamzam Health Center Kashai Dispensary, Kagemu Dispensary, Ijuganyondo Dispensary and Kahororo Dispensary were exposed to just one type of weighing scale in the form of hanging dials with a seat hung from the hook of the balance. One woman commented:

> *"My child who is four years old is supposed to use a standing weighing scale and not the hanging weight scale which he has been forced to use. I'm afraid this scale may even collapse and cause injury to my child. Look at the way my child is weighed! Why can't you tell them to bring a standing weighing scale and also a scale for new borns? 22*

Only Buhembe Dispensary had three types of weighing scales of which two are seen in Figures 4.6 and 4.7.

22 Interview, name withheld, patient, RHC: 16th December, 2008

Figure 4.6 Improper weighing scale for a four year old child at Zamzam Health Center

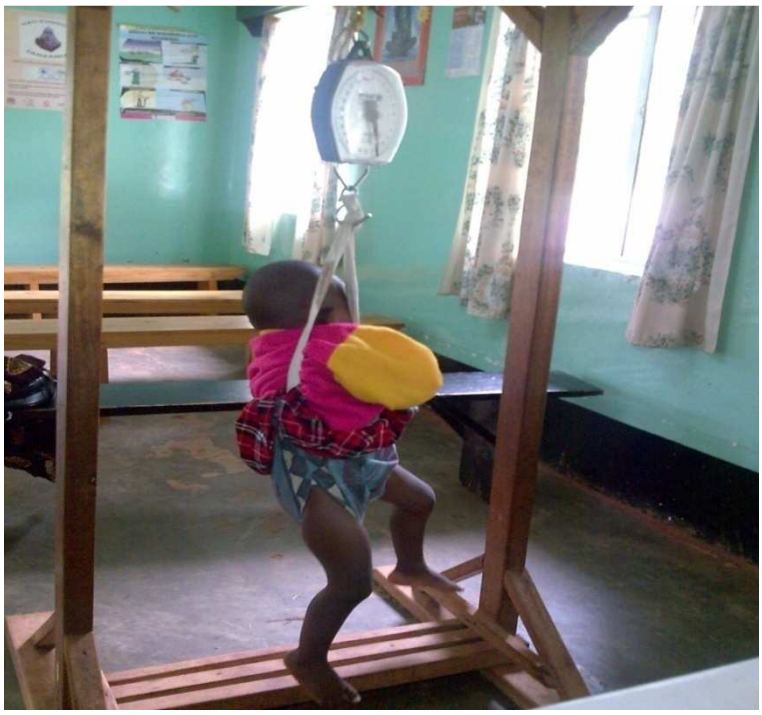


Figure 4.7: A baby in a proper weighing scale at Buhembe Dispensary

Other important facilities which were not available in health centres of Zamzam and Rwamishenye 23 include a maternity ward, a labour room, a patient rest room, an ambulance service, and a standby generator. A medical in-charge of Rwamishenye Health center complained:

23 These are only two health centres within Bukoba Municipality.

This facility does not meet the minimum requirements of a functional health center. We might as well call it a dispensary. We don't work 24hours as required, we don't have an ambulance, we don't have a maternity ward or any ward for admitting patients, there are few staff, we don't have a medical doctor, there is no standby generator and even the pharmacy technician is not available24.

5.0 Conclusion and Recommendations

The study revealed that, the medical personnel and users were dissatisfied with the quality of health services delivered by BMC. The delivery of quality health services was hampered by obstacles related to technical competence, access to service, affordability, interpersonal relations between clients and health staff, reliability of services and amenities. This situation was certainly not likely to support delivery of quality health service that leads to enhanced work productivity, education performance, life expectancy, savings and investments, and reduced expenditures on health care.

In light of the above information and findings from primary and secondary sources, the study came up with the following recommendations on improving the quality of preventive, curative, promotional or rehabilitative health services:

General Recommendations

- Partnership between and among different levels of government and with the private sector and civil society organisations is necessary, to increase accessibility and quality of health services. This requires clear delineation of complementary roles and responsibilities.

- Addressing the challenges of human resource development by supplying sufficient numbers of staff and ensuring that they are well trained and motivated ; there is also the need to deploy a rigorous service supervision at the appropriate health service level.

- Strengthening the capacity of the Ministry of Health and Social services to oversee health services reforms and strengthening of health services' management.

Ensuring that the required central support system is in place that can deal with the financing and/or provision of needed personnel, accounting and auditing, supplies, equipment, physical infrastructure, transportation and communication. Mobilising, aligning and

24 Interview, Mr. Verus Kweyamba, In-charge, RHC: 12th December, 2008

managing financial resources with the view to ensuring that patients receive the intervention they need in a timely fashion.

- Consulting and involving present and potential users of health services, as well as those who work in them and use their views to improve the service provided.

- A countrywide system should be installed to assemble and analyze complaints of patients and even staff that can be tackled through normal budgetary outlays or simply through better work reorganization.

- Government and stakeholders should carry out a comprehensive review of the countrywide application of user fees and declared free services to see how to meet the realistic situation that satisfies both the objective of poverty reduction among the poor and funding needs in the health units.

Specific Recommendations

At the Municipality level, it is recommended that:

- BMC should have their own municipal hospital.

- BMC should work out a better framework for health services complementarity and cooperation among government, municipal and private health units so as to allow better sharing of facilities, health care workers, equipment and drugs, which is crucial in a situation of endemic scarcity.

- A system should be devised and installed in all health facilities to ease out congestion and overcrowding in narrow spaces where patients can be the cause of new infections while they wait for services.

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The Economic and Social Research Foundation (ESRF)
51 Uporoto Street (Off Ali Hassan Mwinyi Road), Ursino Estate
P.O.Box 31226
Dar es Salaam, Tanzania.
Tel: (+255) 22 2760260, 2760751/52
Mobile: (+255) 754 280133
Fax: (+255) 22 2760062
Email: esrf@esrf.or.tz
Website: www.esrftz.org