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Local Primary Health Care Committees and Community-Based Health Workers in Mkuranga District, Tanzania: Does the Public Recognise and Appreciate Them?

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ABSTRACT A study was conducted to explore the views of villagers on the existence and functioning of local primary health-care (PHC) committees, village health workers (VHWs), skilled staff at government health facilities and their responsiveness to community health needs in Mkuranga district, Tanzania. Information was collected through separate group discussions with some members of households, local PHC committees and district health managers and semistructured interviews with individual household members, clinical and nursing staff at peripheral government facilities, and indepth interviews with officers in central and local government departments at district level. Some villagers did not recognise the existence of VHWs and PHC committees at community level. There was a common report from the village respondents that some nurses behaved impolitely to antenatal clients. Dissatisfaction with diagnostic and prescription skills of rural medical-aides and laboratory services was reported by the majority of the residents, albeit some health staff were not happy with villagers complaining while knowing the constrained health staff working conditions.To ensure a sense of public trust, ownership and use of the existing health service system, community members need regular and timely feedback on health service delivery constraints and the existing community based health organisations for them to effectively participate in health development matters.

INTRODUCTION

The goal of the Tanzanian national health policy is to improve people's economic well-being of all the people at health risk by having a health system that is responsive to local people's needs (Collins, 1994; Mills et al., 1990). The Ministry of Health (MoH) emphasises that health facility in-charges are responsible to work hand in hand with the village leaders and feedback given to each other through established structures or mechanisms that are mandatory at each level i.e. household-hamlet-village-ward-district-regional-national (MoH-Tanzania, 2002a).

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The use of village health workers (VHWs) (sometimes known as village health volunteers) and local government leaders in community mobilisation and service delivery has been a practice in Tanzania in interventions like immunisation programmes, health education, environmental conservation, health resource allocation, and in resource mobilisation programmes such as cost recovery schemes (Beeker et al., 1998; Ghebreyesus et al., 1996; Rifkin, 1996). Nevertheless, knowledge and communication gap has remained significant between health providers and village-community levels in Tanzania (Mahler, 2000).

Many countries reforming their health sectors appreciate the importance of involving community members in health service assessment and priority setting through decentralisation policies (Mubyazi and Hutton, 2003; Solomon et al., 2001). Lessons from Cuba show that communities are seen as policy deliverers, creators of solutions and the context in which problems have to be

understood (Greene, 2003). The Alma-Ata Declaration of 1978 emphasised community involvement in health service affairs as an essential component of the primary health care (PHC) towards better health for all, and preparations for the new millennium requires an increased sharing of experiences, both positive and negative, in pursuit of maximising 'Health for All' and community participation (Zakus and Lysack, 1998).

In some countries, community opinions have been collected through such approaches as the use of suggestion boxes, public meetings, direct communication between the government or community leaders with individual members of the general public, household surveys and group discussions (Sitzia and Wood, 1997). In countries (such as The Philippines (Ramiro et al., 2001), Tanzania (MoH-Tanzania, 2002b), Zambia (Blas and Limbalamba, 2001; Mcwang'I, 2004; Ngulube et al., 2004) and Zimbabwe (Loewenson et al., 2004), community representation in health service affairs has been through local health committees and health boards. In developed countries such as Australia, UK and USA, patients' charters give an opportunity for patients to express their satisfaction with the quality of care following the growth of consumerism (Sitzia and Wood, 1997; Wiseman et al., 2003).

Although stakeholders' opinion concerning health is advocated, collecting and making a generally acceptable conclusion based on different opinions from different opinion givers is a complex task, bet it in developed or developing countries (Abelson, 2001; Dolan et al., 1999; Jewkes and Murcott, 1998; Sitzia and Wood, 1997).

This paper describes in more details a study undertaken in 2002 in Mkuranga district, Tanzania to obtain the opinions of local residents and the district level officers about the presence and performance of peripheral health facility staff, village health workers and local PHC committees. It also describes the self-assessment by health-facility-based staff about their job and the rationale for the rest members of the community to evaluate their performance. The paper cites a bit some findings from a comparative case study of four districts published in another article (Mubyazi et al., 2004) but adds new useful information from one district which despite its relevance could not be published in the previous article due to the journal's page and word count limits.

METHODOLOGY

Study Objectives and Design: This study was an exploratory multiple-case embedded in design (Mubyazi et al., 2004), aiming to describe the (a) knowledge and perception of community members, health service providers and district level central and local government officers about the existence and performance of structures and authorities responsible for community health priority setting and service delivery. Emphasis was on the extent to which local PHC committees and personnel involved in health service delivery at community level, particularly the village health workers (VHWs), members of the village and ward development committees (VDCs, WDCs), and health staff at peripheral PHC facilities fulfilled their responsibilities.

Study Area and Population: The study was carried out in Mkuranga district, along the coast of Eastern Tanzania (south of the city of Dar Es Salaam). The main economic activity is small-scale farming of maize, cassava and coconuts and the main residents are Zaramo and Ndengereko (Mubyazi et al., 2004). At district level, CHMT* members and Officers working in the central and local government departments were approached while at community level, the following study population groups were approached: members of ward and village development committees (WDC and VDC, respectively), individual heads of households (or their representatives where a head of household was absent at the time of the interview), and groups of a selected number of any adult members of households who gave their views in the informal group discussions.

Data Collection Techniques: The study applied a mixture of interviews and focus group discussion (FGD) techniques to different categories of study population individuals and groups. Separate FGDs targeted groups of members of households, VDC, WDC, and CHMT. Individual indepth and semi-structured-interviews were applied to clinical and nursing personnel at government health facilities and heads of households (or their representatives), respectively.

Several data collection techniques targeting different types of respondents in opinion giving were applied as experience has shown that house-house surveys to elicit public views in health care may be systematically different when the public is given an opportunity to discuss the issues (e.g.

in FGDs) as opposed to individual interviews or direct investigation with the patient concerned (Dolan et al., 1999; Wiseman et al., 2003).

Sampling Techniques and Sample Sizes: Although interest was to get views from different localities in the district but this could not be accomplished in the wake of constrained time-frame and financial budget for the study. Only four Wards (an administrative locality comprising at least three villages) were selected from different Divisions[+] in the district. From each ward, one village and one health facility available (be it a health centre or dispensary) was selected. FGD participants and indepth district level interviewees were purposively selected. Household level individual respondents were selected randomly by approaching two or three households from different hamlets in the village in which one person was interviewed per household, the target being 10 household respondents per village. To maximise the reliability of the potential service users' views concerning government health care services, attempt was made to select villages located within the catchment area of the health facility selected for study. The villages and their corresponding divisions in which FGDs and household survey were conducted include Kizapara (Mkamba Division), Mwandambaya (Mkuranga Division), Kalole (Kisiju Division), and Vikindu (Vikindu Division). Indepth interviews with key informants targeted in-charges of Kisiju and Mkamba Health Centres and Mwanambaya Dispensary.

In total 40 household members (10 from each of the four selected villages/wards) and two district level officers (the district planning officer-DPLOs and the acting district administrative secretary- Ag. DAS) were involved in the individual interviews. It was decided to interview only 10 individual household members in each locality because based on the experience obtained during pre-testing of the data collection tools and the baseline survey the questions required several probes in a way to maximise the response especially on key study aspects. It was taking about 40-45 minutes to complete an interview with one respondent. This made the whole process tiresome as most of the respondents seemed to spend 40-45 to accomplish the interview because more time was spent explaining and emphasising certain issues that seemed to be of relative importance to them. Moreover, experience from the baseline survey showed that the answers obtained from the respondents were quite similar on many study aspects/questions. This made the research team see no need and justification for covering a large number of interviewees, leave alone that it would not be feasible due to financial and time constraints.

Ethical Issues: After the national ethics clearance was obtained, letters of introduction of the study were sent to the district government and health service authorities who also gave approval for the study to be carried out. Local study population were approached by presenting letter of acceptance of the study from the district and central government authorities followed by attempt by the research team to seek for informed consent directly from the study participants at the time of study visits in their areas. The respondents were asked to sign a special form as a way to express their consent after requesting them verbally to participate in the study interviews or FGDs. Signatures were obtained only from those who felt it was important to sign. Doubts were cleared to all the study participants concerning any information they would wish had to be treated confidential as well as assuring no penalty to anyone who was not ready to participate or wished to withdraw anytime from the study.

***Data Analysis*:** Information obtained using data collection techniques was analysed in triangulation. Debriefing summaries of qualitative information from individual FGDs and interviews were prepared each day immediately after data collection, but a comprehensive transcription was done after completion of the whole data collection process in the district. Some data collected using a semistructured questionnaire were analysed either manually on a sheet of paper and some in MS-Excel software package and summarised in descriptive form.

RESULTS

Villagers' Recognition of Existence and Functioning of VHWs and PHC committees

While the district level officers and ward officers reported that such type of community-based workers and dispensary and health centre health management committees, village health committees, and WDC existed in accordance with the government decentralisation policy guidelines, there was low recognition of the existence and functioning of the VHWs and PHC

committees among the household respondents and group discussants at village level and among the health service staff. Even the term PHC committee at first seemed to be less clear among some household respondents as if it was something they never knew before. Moreover, FGD participants in some villages did not know whether or not the VHWs were present in their villages.

Less than half of the household respondents from the four different community localities and some FGD participants in all the four visited village localities were aware of the duties and mandates of local PHC committees. In one of the study villages, some FGD participants reported that in the previous year local PHC meetings were not held as expected, one of the reasons being the political ideological differences between local community health representatives (PHC members) and ruling party leaders at ward and district level. It was also reported that in Kisiju ward there was a feeling among some opposition party followers that they were not valued/ respected by the members of the ruling party at ward and district level including the district executive director who belonged to the ruling party.

In Mkamba ward, the Kizapara VDC members mentioned the presence and proper functioning of VHCs and VHWs. However, only 14(35%) of all household respondents throughout four study settings in the district expressed somehow being satisfied with the performance of their representatives at village health committees some of whom also being local government leaders. Their partial satisfaction was based on the fact that at least such leaders and committee members attempted to visit their residents to sensitise them on health matters such as HIV/AIDS and environmental sanitation and listening to community health concerns. But 22(55%) household respondents were dissatisfied with their representatives at PHC committees, and 15 out of such 22 respondents gave the following reasons (number of responses indicated in brackets): failure of PHC committee members to provide community members with proper health advice and following-up implementation of the launched health interventions (7/22), acute and long-time shortage of clinical and nursing staff (3/22), village leaders only participating in health campaigns rather than following to ensure that services are actually delivered (3/22), villagers being forced to participate in cost sharing programmes (1/22), and health facility building remaining poor for many years (1/22). In Kalole Village (in Kisiju ward) one head of household that,

"*I only saw the district commissioner visiting us to see the status of some water-wells during cholera outbreak at the beginning of this week*',

At the district level, CHMT members and the district planning officer (DPLO) admitted that in some areas local PHC committees did not function satisfactorily especially in community health priority setting process and representing the community at higher health authority levels. With regard to community participation in health planning and health service management, the DMO argued,

"*We have given communities enough opportunity, although I know they are good at complaining*".

Probed further to clarify what was the nature of complaints, it was lamented,

"*I can't support the current misunder-standing whereby every villager wants a dispensary in his own village*".

Conversely, the DPLO underscored the DMO's office on what was pointed out to be their failure to guide and monitor community members in selecting competent peripheral community health workers, which in some ways has lowered the performance of some VHWs. The DPLO complained,

"*The problem of the people in the health department is that they have failed to select people qualifying for working with communities especially on the sensitisation aspect. They send people who are not trained enough to sensitise and attract villagers for particular services*".

Also the DPLO was dissatisfied with the way local community members sometimes hesitated to take part in health development projects. Responding on why that was the case, it was argued,

"*The community does not see any sense in participating in various developmental projects intended to improve their own life possibly this emanating from their feeling that they are not involved right from the beginning or else they are unconfident in the return they would get from their participation in such activities, especially if they have bad experience from their previous contributions. Sometimes they believe that donors have granted money for everything*".

Nonetheless, VDC and WDC participants in

FGD in all the four wards from four different divisions stated to have been observing weaknesses in the community sensitisation strategy adopted by district health authorities. It was argued that sometimes villagers are mobilised to participate in the campaigns against particular health problems such as cholera and meningitis that have already occurred but not in the period beforehand for preventive purposes. In Mwanambaya village, VDC members acknowledged the presence of two VHWs who were commended for their high commitment despite the poor working environment they were facing that lowered their performance. A similar opinion was obtained from WDC members in Tambani ward. They argued that, without the devotion of VHWs, activities supported by the United Nations' Children Fund (UNICEF) through the CSDP (Child Survival Protection and Development) would not succeed. This point was validated from the viewpoint of the DPLO that VHWs were involved in different seminars with WDC and VHC and that even donors like AMREF (African Medical Research Foundation) and UNICEF used them to run community directed services. Also in Tambani ward, WDC members were concerned with what they said to be the tendency of district level health officers paying themselves high allowances just for outreach and supervision services meanwhile underpaying VHWs. They reported to have heard that UNICEF through the CSPD previously had donated bicycles worth five million shillings but neither community members nor WDC members were involved in knowing whether the real cost of bicycles was equal to the reported amount of money. Their fellows FGD participants – members of the WDC in Vikindu ward were of a similar reservation, as one participant argued,

"*The funds allocated for community health worker services do not reach the targeted people. It is better for the donors to come and pay directly the targeted people instead of channelling the funds through the district health authorities. Instead of paying 5,000 shillings sometimes end up paying only 1,000 shillings per head, which is really bad*".

One CHMT member remarked that,

"*VHWs do not get allowances for their visit to sensitise the community on health matters, so they are demoralised because they also do not have transport*".

The latter point was in line with the argument given by other CHMT members that VHWs were also demoralised to continue working without pay while they sometimes worked in remote villages very far from their own residential villages and some villages e.g. in Mkamba Division are located in places risky to reach by foot because of the occasional presence of wild lions. The district cold chain operator interrupted the latter point by saying that the problem of unpaid allowances to VHWs has been solved ever-since.

Public Trust in VHWs, Local PHC Leaders and Health Service Staff at Public Facilities

Regarding the little confidence community members have regarding the competence of staff at peripheral government health facilities in terms of diagnosis and prescription, FGD participants in Kalole VDC in Kisiju ward claimed that,

"*Recently people have been measured their height instead of their weights in order to be given anti-filarial drugs*",

referring to the ongoing mass drug administration strategy of the National Lymphatic Filariasis Elimination Programme (NLFEP) under the Ministry of Health. However, the clarification obtained from the NLFEP staff showed that the technique of measuring people's height was actually used whereby below a certain height limit, no medication could be given, this indicating the ignorance the community had about the criteria used in the prescription of anti-filarial drugs.

Another concern expressed by the FGD participants in Kalole WDC is the shortage of health service personnel at the Kalole Health Centre. They claimed,

'*Our health centre needs adequate and qualified health staff like other places such as Kizuiani Health Centre in Dar es Salaam. The clinician in-charge of our health centre is not known of her qualifications whether he is a nurse or a clinical officer. We need not to be examined by watchmen at the laboratory, we need competent personnel with acceptable skills*'.

This point was later augmented by explanation from the in-charge of the Kalole Health Centre who said that the current laboratory attendant was previously a watchman at the same Health Centre before he attended a short course on laboratory diagnostic techniques.

Likewise in Mwanambaya village, VDC expressed their dissatisfaction with the local PHC facility staff, as one village government leader

remarked while supported by the rest of the FGD participants,

"*Due to lack of laboratory diagnostic and laboratory facilities, we are not confident in the diagnoses and prescriptions made to patients. Their improper diagnoses maybe are contributed by the presence of a female health facility in-charge whom we are told that she is a rural medical aid* (RMA). *All the village dispensary staff are women who do not take it seriously to show respect when delivering services to men as compared to women*".

Similarly, one household respondent in that village stated to that as villagers 'they were tired of assistant clinical officers'.

Sixteen (40%) of household respondents said that essential drugs were inadequate at health facilities, and in connection to this point, one respondent in Mwanambaya village claimed that as villagers they had a feeling that the acute shortage and stock-outs of drugs at our health facilities was contributed by the dishonest staff who sell drugs to private pharmaceutical traders. Conversely, the female staff in-charge of the dispensary commented,

"*People of this area have much interest in injections, they don't believe even when they are given proper prescriptions*".

She added that staff at the dispensary she worked had been getting little cooperation from members of VHC and VDC, giving an example that when the village government was one time approached to assist mobilising community members for clearing grass around the dispensary, that they complained that they were tired of volunteering. Regarding community complaints against poor services, she argued,

"*The VDC usually start at ten a.m. when patients are already too many here. For example, I did not attend the last one on the 18th February this year (2002) because of reasons like that*".

At one Health Centre, WDC members (among whom was a ward councillor) condemned nurses for their harsh language and impoliteness when dealing with pregnant women, a situation that lead to a considerable number of pregnant women opting to deliver at home. This viewpoint was shared by the DPLO who commented that,

"*Pregnant mothers have decided to deliver at home as a way of avoiding insults from health workers*".

Moreover, such WDC participants reported to be dissatisfied with health personnel at the health centre level for their habit of reporting late at work thereby causing unnecessary inconvenience. For example, patients and antenatal care clients had to wait a long time unnecessarily for the service. In connection to these accusations, the ward councillor testified that the clinical officer in-charge who was misbehaving at the health centre was transferred to another place after the WDC on behalf of the community had requested the district health authority to take disciplinary action.

DISCUSSION

Recognition of PHC Committees and VHWs

The reported irregular local PHC meetings that seemed to have disappointed some community members and the presence of some community members who were not aware of the existence, mandates and functioning of such committees reveal that even if such committees and representatives were present, some residents would not have been able to approach them to express their health concerns.

As only in one ward some village residents appreciated the performance of PHC committees is a reflection of the variations in the effectiveness of PHC committees between areas in the same district. On the other hand, the inadequate performance of VHWs attributed to the difficult working conditions of health workers makes it evident that it is something not to take it for granted that health workers will continue volunteering without some incentives, considering the time they waste working for the community instead of working to serve their own families.

Dissatisfaction with Clinical Assistants and Nursing Staff

Similar evidence about health service users' dissatisfaction with the behaviour of nurses has also been reported from other countries such as Canada (Beardwood et al., 1999) and Zimbabwe (Beeker et al., 1998). It has been argued that the delivery of PHC services is meaningless if the target service users are disappointed by the quality of the service (Murray and Frenk, 2000). The present study have revealed that both the majority of community members and some of their leaders were discontented by the misbehaviour of the nursing staff working at government

reproductive and child health clinics who drive some pregnant women out of formal clinics. There is a possibly that such misbehaviours have contributed to the reported little cooperation by the local government leaders to the in-charge of the Mwanambaya Dispensary.

However, it is important to recognise the conditions that might have had contributed to the observed misbehaviour of the nurses. One of the conditions is the heavy workload staff might have been facing due to dealing with many service clients attending health facilities, thus making the staff get very tired and misbehaving unintentionally. Another possible condition is the stock-outs of some essential drugs although the community associated such drug shortage with dishonest by some health staff.

Service Users and Service Providers Condemning Each Other - *Who is Right*?

Having representative health workers is crucial to the success of community involvement in health, but the ideal participation will only be achieved if health workers prove themselves capable of meeting the health needs of those they serve (Zakus and Lysack, 1998). In Uganda some community members in Mukono district stated their dissatisfaction with the elected local leaders for failing to involve them in setting health priorities, contrary to their lack of interest as reported by the leaders (Kapiriri et al., 2003). A study in Saradidi district in Kenya found communities being disappointed when local meetings were not convened periodically as expected (Kaseje, 1998). In this study, the view by some health service staff that sometimes village residents were over-ambitions for services that could not be delivered under the existing health service delivery constraints that were beyond the ability of health staff to control may be relevant on one hand. On the other hand it might have been unfair for the health service staff judged the service users as ‘good at complaining’ because sometimes people have a reason and right to complain as they are the target beneficiaries of the health services. Meanwhile the disappointment by some community leaders that female clinical staff did not behave well to male patients may be due to their psychosocial perception about women rather than the actual behaviour of such staff, and this may make one to doubt about some of the accusations expressed against such staff. Evidence from other country studies on quality of care indicates that there is a dilemma from the provider’s perspective that although optimally care should be capable of meeting client’s emotional and psychological needs, in reality care that meets all medical needs may not meet the client’s emotional or social needs, while care that meets psychological needs may leave the clients medically at risk (Aldana et al., 2001).

CONCLUSION AND POLICY RECOMMENDATIONS

Based on findings from this study it can be seen that officially PHC committees and VHWs are known to exist at community level, albeit they were inadequately or completely unrecognised by the majority of village residents. Whether or not community members had higher expectations than required on the performance of such committees and health workers, the key take-home message is that more concerted efforts are required towards improving the functioning and responsiveness of such committees and workers in line with community needs. One of the ways forward would be to ensure that community members are adequately and regularly sensitised, given an opportunity and facilitated where necessary to elect/select their representatives who are capable and committed to work at community level on affairs related to health and to give them feedback of what is going on in the health sector. This will help to make them aware of the real situation especially in situations of health service delivery constraints so that they cannot lose confidence in the health service delivery system and to participate in the suggestion of possible solutions. Meanwhile, health authorities (MoH and district local government council) should ensure that health facilities are served by qualified health staff based on their training background, although without close and regular monitoring of their performance at community level, even the highly trained staff may not work according to ethics for their jobs. As for how effective VHWs might be, lessons from Ghana’s trachoma control programme using community volunteers in drug distribution (Solomon et al., 2001) would be useful. Furthermore the present study suggests periodic evaluation of health service and health sector performance involving various health service

agents in districts implementing health sector and local government reforms. The evaluation process should include researchers with the advantage of reporting little or no biased results than would be the case if only those in the health service delivery and management system were involved.

Competing Interests

'The authors declare that they have no competing interests'

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