Factors influencing acceptability of community health workers by community members in Ulanga district

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FACTORS INFLUENCING ACCEPTABILITY OF COMMUNITY HEALTH WORKERS BY COMMUNITY MEMBERS IN ULANGA DISTRICT

By

Dastan Andrew

A Dissertation Submitted in (Partial) fulfillment of the Requirements for the Degree of Master of Public Health of

Muhimbili University of Health and Allied Science
October, 2020

CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation titled; **‘‘Factors influencing acceptability of community health workers in Ulanga District’’,** in (partial) fulfillment of the requirements for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences.

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Prof. Japhet Killewo

(Supervisor)

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Date

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I, **Dastan Andrew**, declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature………………………………….. **Date**…………………………………….

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DEDICATION

I dedicate this dissertation to my wife Glory Brown, mother Esterial Nchali ,Young Sisters and lovely Uncle William Pima for their enduring love, encouragement and support to me all the time.

ABSTRACT

Background: Community Health Workers (CHWs) are a powerful force for promoting healthy behaviors and extending the reach of health systems around the world. CHWs play an important role in improving population health where health workforce resources are limited and access to basic services is low. Although CHWs play a key role in the health of communities, there is an issue of acceptability from community members and health professionals because CHWs are usually residents in the community in which they work, where it is assumed that, they automatically receive support from community and stakeholders. The study therefore aimed at assessing the understanding and the level of acceptability of Community Health Workers in the community.

Objective: The main objective of this study was to assess factors influencing the acceptability of Community Health Workers in Ulanga district.

Materials and Methods: The methodology employed a cross-sectional descriptive study design involving community members receiving services from Community Health Workers who had been trained in a nationally recognized one-year program. A multi-stage sampling technique was applied to select a sample size of 249 community members; adjusting for an assumed non-response of 10%.The total number of community members targeted for the study from five-wards was 275. A structure questionnaire was administered to selected community members to collect data. The Statistical Package for Social Sciences (SPSS) and Microsoft excel were used for data analysis. Frequencies, percentages, and descriptive. Descriptive statistics were used to summarize demographical characteristics, frequency tables used to summarize categorical and continuous data. For continuous data, means and corresponding standard deviations were computed.

Results: The age of the study participants ranged from 19 to 81 years with a mean of 2.41 (SD= 1.7) years. The study finding indicates that 65.5% they have agreed CHWs are accessible in the community to provide health services, while 70.2% they have satisfy with the service delivered by CHWs, moreover on trust 73.1% of the respondent shown high level of

trust to CHWs. Furthermore, the study concluded that community need of health services and the credential of CHWs are essential towards strengthening health services.

Conclusion and Recommendation: The study recommendations are including the ministry level to consider the work condition of CHWs. The district to ensure number of CHWs are enough in the communities Community members to embrace the role of CHWs towards strengthening of health services in their areas; Further research to cover other non-study wards and factors influencing acceptability among the high number of community members without primary education.

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ABBREVIATIONS

CBET	Competency-Based Education and Training
CBHP	Community-Based Health Promotions
CHEW	Community Health Extension Workers
CHWS	Community Health Workers
DoH	Department Of Health
	Elderly and Children
MoHCDGEC	Ministry Of Health Community Development Gender
MoHSW	Ministry Of Health and Social Welfare
NACTE	National Council for Technical Education
NGOs	Non-Government Organisations
PCH	Primary Health Care
PHSDP	Primary Health Services Development Plan
QDA	Qualitative Data Analysis
REACH	Recal and Ethical Approaches to Community Health
SPSS	Statistical Package for Social Sciences
VEO	Village Executive Officer
WHO	World Health Organisations

DEFINITIONS OF TERMS

Community health workers: Should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers have

Acceptability: Is the characteristic of a thing being subject to acceptance for some purpose. A thing is acceptable if it is sufficient to serve the purpose for which it is provided.

Community: A particular area or place considered together with its inhabitants.

Stakeholders: Are the people who have power to influence decisions and the ability to change the direction of a certain project or programme.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

1.1.1 Community health workers context

The umbrella term “community health worker” (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they come. (1)A widely accepted definition was proposed by WHO Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers have (Sanders, 2007) . The first example of a large-scale CHW program was in Ding Xian, China, in the 1920s. (H. B. Perry, Zulliger, & Rogers, n.d.) At that time, Dr. John Grant of the Rockefeller Foundation assigned to Peking Medical University, and Jimmy Yen. A Chinese community development specialist. with a background in teaching literacy to adults, trained illiterate farmers to record births and deaths, vaccinate against smallpox and other diseases, give first aid and health education talks, and help communities keep their wells clean. These services delivered by what originally known as Farmer Scholars, who later became known as Barefoot Doctors in communities where the infant mortality was more than 200 deaths per 1,000 live births and life expectancy was only 35 years. This CHW program grew rapidly, parallel to and in close coordination with the people's communist movement. By 1972, an estimated one million Barefoot Doctors were serving a rural population of 800 million people in the People's Republic of China or roughly one per 800 people.(H. Perry & Zulligler, 2012) Community health workers (CHWs) are a powerful force for promoting healthy behaviors and extending the reach of health systems around the world. CHWs play an important role in improving population health where health workforce resources are limited and access to basic services is low. Most of the countries around the world were facing challenges of health workers especially in Africa and Asia. It estimated a shortage of 4.25 million workers, that cause an inequitable distribution of health workers within countries and the need to accelerate progress in reducing the disease burden arising from readily preventable

and treatable conditions throughout the world, Due to those situations the interest of community health workers was increased. (H. B. Perry et al., n.d.)

1.1.2 Community health workers in Africa

Since the 1978 Declaration of Alma-Ata, the World Health Organization (WHO) has promoted the wider use of community health workers (CHW) to provide clinical interventions and promote healthy behaviors at the community level. The current push is to shift high impact interventions to lower cadres of skilled and unskilled workers to optimize the accessibility and efficiency of health services. Promoting engagement of health care workers at both at the community and facility level remains central to this initiative, as it contributes to a higher quality of care, increased productivity and lower rates of attrition. (USAID, 2010) In Sub-Saharan Africa, most countries seemed to have an interest in achieved Goals (MDGs) in the 1990s, saw they renewed interest in CHW. Because they want to adopt Sustainable Development Goals, which were to ensure healthy lives and promote well-being for all at all ages. CHWs who work to educate, empower and mobilize the community, have played key roles to reduce morbidity and avert mortality in mothers, newborns, and children.(H. Perry, 2013) An example is Uganda where they will meet and exceed the MDGs 4 and 5, in part due to a strategy, whereby 15 000 CHWs were trained to educate women and their families in maternal and child health issues. (Singh, Cumming, & Negin, 2015)

1.1.3 Community health workers in Tanzania

The government started to emphasize the use of CHWs dates back to the mid-1960s when medical auxiliaries and village medical helpers trained to run health posts in order to promote access of health services. In 1983, the Ministry of Health and Social Welfare (MOHSW) developed a guideline for training primary healthcare workers in every village. (7) Even though the MOHSW was developed, the guideline for training but still there was limited of actual service delivery. (Ministry of Health and Social Welfare, 2014).Thereafter, many NGO-led vertical programs resulted in heterogeneous CHWs often working in an uncoordinated manner. The lifetime of these CHW programs was quite short, with a median of 4 years, through programs with dedicated financial support and or a narrow disease focus had more

durability. (Mpembeni et al., 2015) Ministry of Health and Social Welfare has realized that it is important to have a cadre that will strengthen the linkage between the facility and the community in the provision of health and social welfare services. Hence, introduce a Community Health cadre, which comprises the functions of Medical Attendant, Community Health and Para-social workers to serve the purpose. Through collaboration of MoHSW and NACTE has developed Competence-Based Education and Training (CBET) curriculum to standardize training of the cadre and this curriculum make a significant contribution to national development by providing quality training for Community Health cadre in the Country which is responsive to the changing of health and social welfare needs of individual, families and community. (Ministry of Health and Social Welfare, 2015) Even though CHWs possess the necessary knowledge and skills to provide health education and services to their communities there an issue of acceptability of community health workers in the health system and community of which they are a part of the context in which they work. Therefore, the researcher is going to assess acceptability of community health workers in the community.

1.2 Statement of the Research problem

In March 2014 the Ministry of Health and Social Welfare has certified National Guidelines for the Community Based Health Program. The program was aimed at increasing the health workforce in the community who will perform day to day, routine works in the area of community health, and supportive health services and be able to cope with the emerging issues in the community.(Ministry of Health and Social Welfare, 2015) Regardless of those efforts taken by the MoHCDGEC in Tanzania, different regions managed to deploy only a small number of community health workers. For example, in Simiyu 62 health workers were deployed, Misungwi, 52 health workers have deployed also Chemba in Dodoma 35 health workers were deployed and Ulanga, 62 health workers were deployed by non- government. In addition, CHWs have been employed by private organizations in Ifakara and Kilombelo districts. CHWs also work in a different setting in the community while others work in health facilities. (Semu, n.d.). CHWs are usually residents in the community in which they work; it assumed that CHWs automatically receive community support however, not always accepted when they begin to operate in the community due to history, past performance or other issues. For example, they might only receive minimal training, at least in the initial stages, and may therefore not have significantly more health-related knowledge than nurses on whose good will they rely to support their activities. A society with low acceptability levels may be a difficult environment for a CHW to operate. This can lead to demoralization of the CHW, attrition and ultimate failure of the program. What we know about the previous cadre is that it was highly acceptable to the communities in which they lived and worked. However, the general communities know little about the level of acceptability of the current CHWs and their services. Therefore, this research is going to assess the factors influencing the acceptability of community health workers and the services they provide in Ulanga District.

1.3 The conceptual framework of the study

The conceptual framework for assessing factors influencing acceptability of community health workers by general community shown in Figure 1. This conceptual framework explains on the relationship between various variables and their contribution methods that a researcher sees that they are common compared to others. The dependent variable is acceptability of CHWs and independent variables are demographic characteristics like age, sex, Marital Status, Occupations, as well as other factors like satisfactions, accessibility, Trust. Acceptability level is associated with Trust, accessibility and satisfactions. Trust, satisfactions, and accessibility of CHWs services, will help to determine the acceptability of CHWs in the community. (Naimoli, Frymus, Wuliji, Franco, & Newsome, 2014)

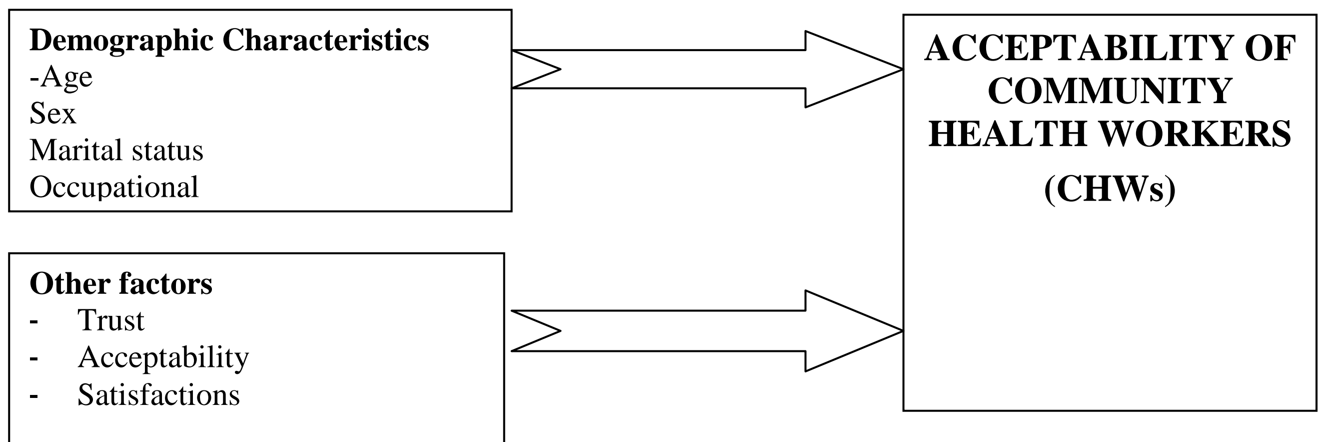

Figure 1: The conceptual framework of the study

1.4 Rationale of study

The study has come at the right time since the government of Tanzania is formalizing the CHW cadre. The findings will help the Ministry of Health and NACTE to be aware of CHWs at what extent CHWs they acceptable in the community in general. Instead of putting larger effort on selecting, training and deployed them to the community. This Study will go hand in hand to determine the challenges facing community at health facility and community. Also, the study will help the ministry of health know the level of acceptability of community health works so as they can reduce or increase the number of enrolled students at the school of health. Finding of study will help to understand the expectations and perception of stakeholder on CHWs and this will help the investigator to come up with a good result on Acceptability of community health workers. Therefore, the result will help the government and other stakeholders to budget for resource allocation to promote and implement the CHWs.

1.5 Main research questions

What are the factors influencing acceptability of community health workers service by community members in Ulanga district.

1.5.1 Specific research Questions.

1. To what extent are community members satisfied with the services of community health workers.
2. To what extent do community members satisfy community health workers in delivering service?
3. To what extent are community health workers accessible to community members to provide service?

1.6 Objectives

1.6.1 General Objectives

To assess the factors influencing the acceptability of community health workers services by community members in Ulanga District

1.6.2 Specific Objectives

1. To assess the level of satisfaction of community members in receiving service from CHWs.
2. To assess the level of trust of community health workers by community members.
3. To determine the accessibility of community health workers in the community for providing required services.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Overview

This chapter explains empirical evidence underpinning the study objective on the factors influencing Level of acceptability of community health workers in the community

2.2 Satisfactions of community members in receiving service from CHWs

Community Health Workers as an Integral Strategy in the REACH U.S. Program to Eliminate Health Inequities. The study has shown that CHWs have decreased the number of emergency room visits among disparate populations by as much as 40% and CHWs have provided a return on investment of more than $2.28 for every $1 invested by shifting inpatient and urgent care to primary care (Elizabeth, Rachel, & Richard, 2006). These types of results, coupled with CHWs' contributions to increased patients' knowledge, improved behavioral and health outcomes. In multiple health priority areas, represent reductions in health disparities and have sparked a growing interest in advancing the CHW frontline workforce. For example, in 2010, the Department of Labor recognized the CHW workforce, and various federal, state, and other entities acknowledged CHWs. As necessary members of community health teams that have a patient-centered perspective and a preventive approach, especially in underserved communities.(Martha Monroy, Carolyn Jenkins, Sheila R Castillo, 2015) In Taiwan, a study addressing patients’ satisfaction revealed that most participants were employed females residing with partners. They were satisfied with the visit from CHWs agents who came once a month, also this prove that there is high acceptability of community health workers to the patients, because patients' level of satisfaction seemed to be increased when community healthcare workers visited the family twice a month. They provided services like preventative care, e.g. providing a rotavirus vaccine for children and taking care of children with diarrhea. A study was done to examine the level of satisfaction in the home, concerning healthcare services residents received from primary caregivers. Results showed that there were overall satisfaction levels regarding home health care. The satisfaction was higher and acceptable

where the primary caregivers were older than 30 years and had a lower educational level. The services households received were providing knowledge of the illness, completing the promised tasks, and actively enquiring about patients ‘conditions and needs. Most of these services are part of the primary health care service and it is beneficial when they can be delivered to a patient’s home.(Makgobela, Ndimande, Ogunbanjo, Bongongo, & Nyalunga, 2019)

2.3 Trust of community health workers in delivering health service in the community members

In South Africa, introduced the Department of Health (DoH) to address this challenge is the re-engineering of primary health care (PHC). An important component of this initiative is the deployment of CHWs in communities to visit pregnant women and new mothers in their homes to provide key health promotion messages. The use of CHWs aims to provide appropriate, accessible care and bring care closer to mothers and babies, bridging the service delivery gap in underserved communities. However, they were received challenges on the Lack of confidentiality and trusts were expressed as a major barrier to CHW acceptability. CHW relations with childcares were complex, and successful interaction was based on trust. When CHWs and childcare were asked about their perceptions of CHWs and confidentiality, some felt that CHWs were trusted, while most felt that community members did not trust CHWs. However, there was agreement that the community would accept CHWs who had a reputation for maintaining confidentiality(Grant M, Wilford A, Haskins L, Phakathi S, Mntambo N, 2017).

2.4 Accessibility of community health workers in the community in providing health service

The accessibility of community health workers in the community was very importance because it enables community to get service at specific time and it easy for community member to accept the serves delivered with community health workers. Example in a study on CHWs working in child health in Uganda, found that households residing 1 to 3 km from a

health facility were 72% more likely to utilize CHW services compared to households residing within more than 3km of a health facility.(Ngeny, 2015) In 2002, Uganda has adopted and implemented community case management for malaria, locally known as home based management of fever. Under this program, community health workers provide pre-packaged anti-malaria drugs presumptively to children that present with high fever. In 2010, this program was scaled up to the whole country as a strategy to reduce child mortality by improving accessibility of CHWs in providing health care for sick children in resource poor settings. This program was persuading acceptability of community health workers in the community. (Lingala & Ghany, 2016)The amount of work that a CHW‘s catchment area entails depends on the number of households each CHW is responsible for, the target group within the family (e.g. all family members, children only, women only), as well as the geographic distribution of those households. Should be noted that the community member who is easy to access CHW service is more likely to accept the services delivered with CHWs compare with community member who facing challenges to access CHW service.(Srivastava, 2008)CHWs can act as catalysts and role models by empowering members of their communities with increased knowledge and support. (20)

2.5 Gap of knowledge

This study intended to assess the factors influencing acceptability of CHWs in Ulanga district. Despite the fact that difference studies have been done in ,Taiwan, Ethiopia, South Africa ,India, and Senegal shown high acceptability of CHWs services in the community. However, in Tanzania since 2014 when the Ministry of health and Social Welfare officially approved and certified a guideline for CBHP for community health workers there was little known on level of acceptability to community health workers service in the community. This study aimed at assesses the factors influencing of acceptability of community health workers in Ulanga district.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Study Area

This study was conducted in Ulanga district, one of the six districts of the Morogoro Region of Tanzania. The administrative seat of Ulanga District is in Mahenge Town. The district covers 24,460 square kilometers and has a total population of 265,203 residents(National Bureau of Statistics Ministry of Finance Dar es Salaam and Office of Chief Government Statistician Presidents office,Finance, 2013).The study was conducted in health facilities and the community environment. This study area was selected because the first batch of qualified CHWs was deployed here in year 2017. This means that out of the 10,000 or above CHWs who have undergone training using the standardized curriculum for CHWs, only less than 100 have been employed and most of these were deployed in Ulanga district. A total of 62community health workers worked in the community and health facilities in villages and dispensaries. Health facilities in Ulanga district include one district hospital, two health centers, 22 dispensaries, 16 of which are government and 6are private.

3.2 Study Design

The study adopted a descriptive cross-sectional study design. A cross-sectional study measures simultaneously the exposure and outcome in a given population and in a given geographical area at a certain time (Levin, 2006). This quantitative method was used to critically assess the level of satisfaction of community members in receiving services from CHWs; Trust of community members to the community health workers and Accessibility of community health workers in the community were assessed.

3.2.1 Quantitative Study

This study design was chosen since it is capable of describing the characteristics of units of inquiry and be able to compare them.(CR., 2004)

3.3 Study populations

The study involved community members age 18- 81 who are currently living in Ulanga district. The study interviewed community members on their level of satisfaction with services received from CHWs.

3.4 Target population

The target population means a group of people whom we want our research results to apply (Thomas, 2017). In this study, the target population consisted of community members who have age 18 – above, currently were living in the community and received primary health care services from CHWs, who were trained in a nationally recognized institution for one year to work in the community to provide primary health care services.

3.5 Sample size calculations (Israel, 1992)

The sample size for the study was calculated using the following formula and parameters as shown in the table:

$$N = \frac{Z^2 P(100-P)D}{e^2}$$

N = Minimum estimated sample size

Z = standard normal deviate =1.96 for 95% confidence level

P = Expected proportion who find CHWs acceptable to their community (50%)

e^2 = The margin of error (desired level of absolute precision)

D = Design effect of

Non response rate = 10%

Estimations of proportions prevalence in%	50
Desired precisions	10
Significant level	5%
Cluster design effect	1.3
Worst acceptable prevalence	40
SRT 2qp/e2	
P	50
Q	50
Z	1.96
z2	3.8416
100-p	50
2pq	5000
E	10
E2	100
Z2*2pq	19208
Sample size=	192.08
Designed effect=	1.3
Final minimum sample size	249.704
Include 10% non-response	275

The minimum sample size was therefore 249 community members; and after adjusting for non-response of 10%, the sample size was finally 275 community members.

3.6 Sampling procedure

The first step was to identify communities where the CHWs are working. The study was carried out in these communities because they will have been exposed to CHWs and their services. CHWs who were trained under the national program can be working either in communities or in health facilities. Hence, the quantitative study was conducted on a selected sample of the general population to enable assessment of acceptability and accessibility. The

study used a multistage cluster sampling technique staring from ward level to obtain the study population. All villages in which CHWs are working were listed together with their Sub-villages "Vitongoji” and their respective populations and a sampling interval determined to arrive at the required sample size. It was very convenient if selected villages had CHWs who work in the community and health facilities to capture both types of CHW stakeholders.

3.6.1 The first stage selection of the wards

A list of all the wards in the district was prepared (Lupiro, Milola, Minepa, Kichangani, Iragua,Vigoi and Nawenge, Ilonga, Ketaketa and Chirombolo) followed by a selection of wards with at least one health facility and at least one CHW. From the above wards, one ward was purposefully selected to proceed to the second stage of the multi-stage process.

3.6.2 The second stage selection of the villages

From the selected ward, (Kichangani)lists of all villages(Kichangani, Idunda, Ikungua) with a health facility (either a dispensary or a health center) were prepared and one village randomly selected. The name of the selected village **was Idunda)**

3.6.3 The third stage selection-using Probability proportional to size

The households to be interviewed were selected based on Probability Proportional to Size (PPS). From the selected village (Idunda) and all sub-villages (vitongoji) which was (kitete, Idunda kati, and Fimbo)were listed together with the corresponding number of households and added to obtain the total number of households for the village. This number was divided by the estimated sample size to obtain a sampling interval of the households then the number of households in each Kitongoji was divided by the sampling interval to obtain the number of households in the Kitongoji from which the head of household was interviewed**.** Ward leaders or Kitongoji leaders were then requested to provide a list of households in their area of jurisdiction. Once the number of households was established in each Kitongoji the researcher and his team consulted the respective Kitongoji leader for assistance in finding randomly selected households. The researcher listed all the households by name, wrote them on separate ballot papers, folded them, put them on a table and shuffled them before asking the Kitongoji leader to pick the right number of selected households with his eyes closed.

3.6.4 Inclusion and exclusion criteria

Inclusion criteria

The study population included in the study was members of communities in which CHWs are working. These CHWs had undergone training for one year in a nationally recognized institution and are currently working either in the community or health facilities in Ulanga district.

Exclusion criteria

Members of communities, which satisfied the inclusion criteria but were not willing to participate in the study or were sick, were excluded from the study.

3.7 Validity and reliability

For achieving validity and reliability, questionnaires designed in such a way that they captured relevant information for the research objectives. Validity explains the accuracy and truth of the data in research, while reliability means that if the respondents or independent observers repeat the research with the same methods, they will acquire the same results or data (Kothari, 2003).

3.8 Data collection tools

Data were collected using mainly closed-ended questions but also some essential open-ended questions were used. Questionnaires were pre-test before being used aiming to test whether the instrument would elicit responses required to achieve the research objectives and/or whether the content of the instrument was relevant and adequate; to test whether the wording of questions was clear and understandable to the respondents. After pre-testing, amendments were made after identifying gaps. Research assistants were dispatched ready for fieldwork to collect data in the study area.

3.9 Data collection procedures

Village authorities, sub-village (Vitongoji) or ten-cell leaders were requested to accompany the research assistants to the first selected household on the leader's list. At the household, the head of household were requested to participate in the study after receiving explanations about the study's objectives. After administering the consent, the research assistants proceeded with the interview. After the interview, the research assistant thanked the respondents and proceeds to the next household on the list for similar interviews. This process continued until the sample size of the study population in the Kitongoji or ten cells was realized. Then the team moved to the next Kitongoji or ten-cell leader to undertake the same procedures until all the selected Vitongoji or ten-cells were covered and the overall sample size realized. At the end of each day, all the filled questionnaires were checked for filling errors and completeness and were corrected and stored in a safe place for data entry and analysis.

3.10 Data analysis procedures

The filled questionnaires were coded, data was entered and analyzed using SPSS Statistics package. Data presented in tables. The researcher also used descriptive statistics to summarize demographic characteristics. Frequency tables were used to summarize categorical data. The Chi-square test used to assess association between a demographic factors and each of the categorical independent variables. A p-value of less than 0.05 was used as a cut-off point for assessing statistical significance.

3.11 Ethical Consideration

Ethical approval to conduct this study was obtained from the Research and Ethics Committee, Muhimbili University of Health and Allied Sciences. Permission to conduct the study in Ulanga district was obtained from the District Executive Directors' office while permission to carry out data collection at village level was obtained from the Village Executive Officer (VEO) or the Kitongoji or ten-cell leaders. Selected participants were given adequate information about the study including purpose, benefits, and the existence of any foreseeable risks and maintenance of confidentiality. Participants were provided with a consent form in which they signed willingness to participate in the study.

CHAPTER FOUR

4.0 FINDINGS

4.1 Background characteristics

The study included 275 respondents according to the sample size. Their ages ranged between 19and 80 years with a mean age of 2.41 (SD = 1.7) years. Age distribution of the study population indicated that 66.9% was in the age group 19-39 years, whereas 53.5% were male and 46.5% were female. Married individuals were 46.5% while those with primary education were 52.4%. The percentage of the population Petty traders was 45.8%.

Table 1: Distribution of study participants by background characteristics

Variable	Frequency (N=275)	Percent
Age		
19 – 39	184	66.9
40-60	69	25.1
61- 81	22	8.0
Sex		
Male	147	53.5
Female	128	46.5
Marital status		
Single	35	12.7
Married	128	46.5
Cohabit	72	26.2
Separated	31	11.3
Widower/widow	9	3.3
Education		
Never	116	42.2
Primary education	144	52.4
Secondary education	8	2.9
College /university	7	2.5
Occupation		
Public and private sector	39	14.2
Farmer	136	49.5
Petty trader	100	36.4

Table 2: Accessibility of community health workers in the community for providing health services

Variable	Responses	Frequency (n)	Percentage (%)
Presence of CHWs	Yes	165	60.0
Number of new CHWs			
	Two	90	32.7
Number of CHWs known by names	One	237	86.2
CHWs visited households	Yes	179	65.1
Services provided by CHW to community members.	Health promotion education	180	65.5
	Palliative Care	64	23.3
	Distribute medicine	20	7.3
	Distribute family planning commodities	11	4.0
Availability of CHWs	Readily available	162	65.5
	Available with difficulty	12	4.4
	Rarely available	61	22.2
Number of visits in the past 1 year made by CHWs	Once	129	46.9
	Twice	125	45.5
CHW reside in same village	Yes	195	70.9
Thinking CHW are enough in village	Yes	163	59.3
Number of CHW selected for Training	One	183	66.5
	Two	92	34.4

Accessibility was measured by presence of CHWs, permanent residence in the same village and whether they knew them by name. Findings revealed that, 165 (60.0%) of the respondents reported that CHWs were present in the community and that 195 (70.9%) of the respondents reported that their CHWs reside in the same village as the respondents. Some of the respondents 188 (66.5%) reported that only one CHW was selected for training in their community while some 88 (35.3%) reported that two CHWs were selected for training. Majority of the respondents 237 (86.2%) reported that they knew the CHWs present in their community by names. Furthermore, results reveal that majority of the respondents 129 (46.9%) reported that they had been visited at least once in past one year while 125 (45.5) reported that they had been visited twice in their household for providing health services in the past one year. In addition, finding indicate that services provided by CHWs to the community were health promotion and education, majority 180 (65.5%) reporting to have received this service. While 64 (23.3%) reported to have received palliative care at their homes. Additionally, 20 (7.3%) reported to have received medicines while 11(4.0%) reported to have received family planning commodities. Regarding availability of CHWs in providing health services to communities 162 (46.9%) of the respondents reported that CHWs were readily available while 61 (22.2%) reported that CHWs were rarely available in the community to provide service. Only 12 (4.4%) respondents reported that CHWs were available with difficulty. Regarding adequacy of CHWs in the community 163 (59.3%) of the respondents thought that the number of CHWs present in their community was enough for providing the required service.

Table 3: Satisfaction of community members in receiving health service from CHWs

Variable	Response	**Frequency (n)** N=275	**Percentage (%)**
How many times you have attended community meeting in the past year	Once	197	71.6
	More than once	78	28.4
In those meetings, you attended, did any of the CHWs present a talk about health issues	Yes	242	88.0
How clear was the topic to you when given by the CHW?	Very clear	193 8	70.2
	Somehow clear	82	29.8
How satisfied were you with the services provided by the CHW at your home?	Very Satisfied	193	70.2
	Somehow satisfied	82	29.8

Findings reveal that, community members are satisfied with the services rendered by community health workers as the majority 193 (70.2%) reported that they are very satisfied with the services they received from CHWs followed by 82 (29.8%) who reported that they were somehow satisfied with the services they receive from community health workers. Regarding the health education provided to the people by CHWs, 178 (64.7%) of the respondents reported that the topic taught was very clear, followed by 95 (34.5%) who reported that the topic taught was somehow clear to them. Regarding participation of CHWs in community meetings, 242 (88.0%) of the respondents reported that CHWs presented health topic in their meeting. Participation of respondents in community meetings indicated that78 (28.4%) had attended more than twice while 197 (71.6%) had attended only one meeting in the past one year. This indicates that most CHWs attend community meetings at least once per year.

Table 4: Trust of community health workers by community members

Variable		Frequency (n)	Percentage (%)
If you face a health problem at your household are you able to call CHWs for help.	Yes	236	85.8
	No	39	14.2
Are you able to discuss freely your health problems with the community health workers in your community?	Yes	201	73.1
	No	74	26.9

The findings of this study revealed that, the level of trust of community members to CHWs is significantly high because community members have trust in community health workers, as they are able to call CHWs when they face health problems in their household. This is indicated by the finding that 236 (85.8%) of the respondents reported that they were able to call CHWs for help while 201 (73.1%) of them reported that they were able to freely share and discuss issues related to health with CHWs. However, 74 (26.9%) Majority who respond No to the above Questions reported that community member have no trust to CHWs, and the reasons that were reported are like; most of CHWs are very young, thus making them uncomfortable to discuss with them on issues related to health such as reproductive health issues, lack of confidentiality and unavailability of some services.

4.2 Accessibility of community health workers in the community for providing required services

The study revealed that CHWs were accessible in the community to deliver primary health care services. However, study shown that there were high accessibility of community health workers service to aged groups 61-81. Even though, those who visited more than one time suggested the number of community health workers were enough to provide primary health care. Nevertheless female seems to access much CHWs .All in all CHWs were accessible in the community in providing primary health care.

However, high number of community member agrees that CHWs are resident at their village and of community members they were received health educations and promotions this shown that most of services derived to the community members were health educations and promotions compare with other services. Other literature shown on this accessibility of community health workers service good.

Table 5: Accessibility of community health workers in providing health services by socio-demographic characteristics of respondent

		Accessibility		
Variable	**Categories**	**Yes (%)**	**No (%)**	**P – Value**
Age (years)	19 -39	109 (59.2%)	75 (40.8%)	0.236
	40 – 60	40 (58.0%)	29 (42.0%)	
	61 – 81	17 (77.3%)	5 (22.7%)	
Sex	Male	69 (46.9%)	78 (53.1%)	0.001
	Female	97 (75.8%)	31 (24.2%)	
Marital Status	Single	30 (85.7%)	5 (14.3%)	
	Married	86 (67.2%)	42 (32.8%)	
	Cohabiting	32 (44.4%)	40 (55.6%)	0.001
	Separation	12 (38.7%)	19 (61.3%)	
	Widower/Widow	6 (66.7%)	3 (33.3%)	
Educations	Never been to school	53 (45.7%)	63 (54.3%)	0.001
	Primary education	106 (73.6%)	38 (26.4%)	
	Secondary education	4 (50.0%)	4 (50.0%)	
	College/university	3 (42.9%)	4 (57.1%)	
Occupations	public and private sector	14 (35.9%)	25 (64.1%)	0.001
	Farmer	73 (53.7%)	63 (46.3%)	
	Petty trader	79 (79.0%)	21 (21.0%)	

Table 5 shows accessibility of CHWs for services provided in the community by socio-demographic characteristics. It was indicate that the oldest age group 61-81 were 17 (77.3%) they were high accessibility in receiving CHWs services compare with others age groups, P-value = 0.236. While finding based on gender, female respondents reported high accessibility, it is about 97 (75%) were accessible CHWs services, P-value =0.001 was statistically significant.

Findings based on the respondent’s marital status shows that there was high accessibility in single group about 30 (85.7%) were slight difference with other marital status groups. P-value = 0.001 it was statistically significant.

Results show that the accessibility of CHWs services in the community on Occupations was about 79 (79.0%) Pretty trades they were high access CHWs service compare with other occupational groups. P-value = 0.001 was statistically significant.

Moreover, findings on Accessibility of CHWs services the respondent was based on level of educations. The respondent who has primary educations was seen to have more accessible CHWs service it’s about 106 (73.6%) respondent compare to secondary and those who did not attending any school. P-value = 0.001 was statistically significant.

Table 6: Satisfactions of community members in receiving health services from community

		Satisfactions		
Variable	**Categories**	**Yes (%)**	**No (%)**	**P – Value**
Age (years)	19 -39	159 (86.4%)	25 (13.6%)	0.178
	40 – 60	61 (88.4%)	8 (11.6%)	
	61 – 81	22 (100%)	0 (0.0%)	
Sex	Male	125 (85.0%)	22 (15.0%)	0.105
	Female	117 (91.4%)	11 (8.6%)	
Marital Status	Single	35 (100.0%)	0 (0.0%)	0.001
	Married	124 (96.9%)	4 (3.1%)	
	Cohabiting	53 (73.6%)	19 (26.4%)	
	Separation	21 (67.7%)	10 (32.3%)	
	Widower/Widow	9 (100%)	0 (0.0%)	
Educations	Never been to school	89 (76.7%)	27 (23.3%)	0.001
	Primary education	138 (95.8%)	6 (4.2%)	
	Secondary education	8 (100.0%)	0 (0.0%)	
	College/university	7 (100.0%)	0 (0.0%)	
Occupations	public and private sector	37 (94.9%)	2 (5.1%)	0.272
	Farmer	120 (88.2%)	16 (11.8%)	
	Petty trader	85 (85.0%)	15 (15.0%)	

Table 6 Findings of individuals based on age reveals that there was a slight difference in satisfied of community health workers services in the community as summarized in table. Satisfied of community member aged 19-39 years 159 (86.4%) was lower than community member aged above 61-81 years it about 22 (100.0%) . this means the community members who as aged 61 years above was seen to have more satisfied to the community health servers than who has below 41. P-value = 0.178.

Findings based on the respondent's gender indicate that, there were differences in Satisfied Community member in received health service from CHWs health workers. Female they have seemed to have more satisfied with community health workers services it is about 117 (91.4%) compare with Male it about 125 (85.0%). P-value = 0.105

Moreover, a finding of Satisfactions to the community members in receiving CHWs service were 8 (100.0%) and 7 (100.0%) for those who had been to secondary school and university/ college. The respondent who has secondary educations and university were seemed to have more satisfied CHWs service compare to primary and those who never been to school. P-value = 0.001 was statistically significant

Results show that satisfied of CHWs services in the community on Occupations was about 37 (94.9 %) of those public and private workers were more satisfied compare farmers and pretty trades. P- Value = 0.272 not statistical significant

Findings based on the respondent's marital status shows that there were differences in groups. About 35 (100.0%) of those who are single more satisfied CHWs services, and widow 4 (100%) compare with cohabiting and married . P-value = 0.001

Table 7: Trust of community members in receiving health services from community health workers

Variable	Categories	Satisfactions Yes	No	
Age (years)	19 -39	158 (85.9%)	26 (14.1%)	0.702
	40 – 60	62 (89.9%)	7 (10.1%)	
	61 – 81	19 (86.4%)	3 (13.6%)	
Sex	Male	138 (93.9%)	9 (6.1%)	0.001
	Female	101 (78.9%)	27 (21.1%)	
Marital Status	Single	20 (57.1%)	15 (42.9%)	0.001
	Married	122 (95.3%)	6 (4.7%)	
	Cohabiting	65 (90.3%)	7 (9.7%)	
	Separation	25 (80.6%)	6 (19.4%	
	Widower/Widow	7 (77.8%)	2 (22.2%)	
Educations	Never been to school	99 (85.3%)	17 (14.7%)	0.717
	Primary education	126 (87.5%)	18 (12.5%)	
	Secondary education	7 (87.5%)	1 (12.5%)	
	College/university	7 (100.0%)	0 (0.0%)	
Occupations	public and private sector	30 (76.9%)	9 (23.1%)	0.030
	Farmer	116 (85.3%)	20 (14.7%)	
	Petty trader	93 (93.0%)	7 (7.0%)	

Findings based on the respondent's gender indicate that, there was a slight difference of Trust to the community member in received health service from CHWs health workers. Male they have seemed to have more trust with community health workers services it is about 138 (93.9%) compare with male it about 101 (78.9%). P-value = 0.001 it was statistically significant.

Moreover, findings of individuals based on age reveals that there was a slight difference in Trust of community health workers services in the community as summarized in table. Trust of community member age groups 40-60 was 62 (89.9%) was higher than community member age group 61-81 it about 19 (86.4 %). this means the community members who as aged 40-60 years was seen to have more Trust to the community health servers than who has be 61-81 years. P-value = 0.702 not statistically significant

Moreover, a finding of trust to the community members in receiving CHWs service respondent based on level of educations. The respondent who has college/university educations was seemed to have more trust with CHWs service it is about 7 (100%) compare to primary school, secondary and those who never been school. P-value = 0.717 not statistically significant.

Results show that Trust of CHWs services in the community on Occupations was respondent 30 (76.9%) of private respondent and public workers, they have trust CHWs service. While there is increasing of Trust in the community health workers service to the petty traders, they have higher trust in community health workers services it is about 93 (93.0%) respondent. P-value =0.030 statistically not significant.

Findings based on the respondent's marital status shows that there was slight difference in groups. About 122 (95.3%) of those who are married seems to have high trust CHWs services compare to another groups. P-value = 0.001 statistically significant

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 Overview

This chapter discusses the findings from the study that aimed at assessing factors influencing acceptability of community health workers in Ulanga district. The acceptability of the Community Health workers focuses on three areas namely accessibility, satisfactions and trust. In the course of discussion, comparison with other studies elsewhere will be made as well.

5.2 Socio-Demographics Characteristics of the Respondents

The following socio-demographic characteristics of the respondents were analyzed by age, sex, marital status, education and main occupation. On the socio-demographic characteristics of respondents are presented in households' respondents were female and male. However, most of majority participated in this study research were men. Furthermore, the study indicates that more males than females receive health services and education support at their households from Community Health Workers. Age of the household respondents most of respondent were adult mean age of 31-40.years .Level of education of respondents most of them were primary educations. The level of education of respondents did not affect level of thinking and acceptability of the CHW. Marital status these results indicate that most the respondents interviewed in the study area were married. This is also adding value as all married respondents were reported to have trust to Community Health Workers and ready to share their health issues upon finding and seeking health services assistances. Main occupation of respondents were depending on public and private sectors activities Despite the fact that this study focused on the acceptability of community health workers service in the community, yet understanding their social and demographic characteristics has the actual focus. Their demographic factors was not much affect acceptability of CHWs service because all member of community was shown high acceptability regardless their status.

5.3 Accessibility of community health workers in providing health services

example study conducted in Uganda stated that " CHWs working in child health in Uganda, found that households residing 1 to 3 km from a health facility were 72% more likely to utilize CHW services compared to households residing within more than 3km of a health facility.) (Lingala & Ghany, 2016) It conclude that most of community members whose nearby community health workers they are easy to received health service compare to those who far away. Therefore, study discovered most of community member in Idunda village they are nearby with community health workers that is why high number of community members enable to receive health service.

5.4 Level of satisfaction of community members in receiving services from CHWs

The study revealed that a majority of community members was highly satisfied because most of them were seen to be satisfied from the services rendered by CHWs relevant to the health topic were presented seems was clear understanding In addition, satisfaction of community members depended on their understanding of the health topics presented by CHWs. However, the attendance of community members at community health workers meeting were highly accepted even though there were other community members who were not attending the community meeting due to their busy schedules. Therefore, those who attending severe times community meeting are the one who satisfied the services and accepted the community health workers. Example of the study "In Taiwan, a study addressing patients' were satisfied with the visit from CHWs agents who came once a month, also this prove that there is high satisfaction of community health workers to the patients, because patients' level of satisfaction seemed to be increased when community healthcare workers visited the family twice a month.). (Makgobela et al., 2019) It concluded that community members accept and satisfied with the services derived by community health workers.

5.5 Level of Trust of community health workers by community members

Findings of this study pertaining to Trust behind becoming CHWs corroborate those community members who received service from CHWs, the study showing most of community members they have highly trusted a CHWs. In additions to this study revealed that, the level of trust of community members to CHWs is significantly high because the community members have trust in community health workers, as they are free to discuss on matters pertaining to their health. Reported that they are able to share and discuss with community health workers on issues relating to health. However, only few of community members reported they have no trust to CHWs, and the reasons that were reported are like; most of CHWs are very young, thus making them uncomfortable to discuss and lack of confidentiality and inaccessibility of some services. Example of study in South Africa The use of CHWs aims to provide appropriate, accessible care and bring care closer to mothers and babies, bridging the service delivery gap in underserved communities. However, they were received challenges on the Lack of confidentiality and trusts were expressed as a major barrier to CHW acceptability.(Grant M, Wilford A, Haskins L, Phakathi S, Mntambo N, 2017).This study indicated that though there is high level of trust still there are few community members whose not trust CHWs but in this study, it did not cause much influence because of few respondents who facing challenges

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The study conducted in order to assess factors influencing acceptability of community health workers service in Ulanga district. Conclusions given based on the findings of this study from the first objective, found that accessibility of the community health workers in the community was good and the community could benefit from services offered by the community health workers. Therefore, health services provided by CHWs are essential towards strengthening health services of the community. Second objective on satisfactions. The findings showed that most of the respondents were very satisfied with the community health workers services. Based on this finding, Health services provided by community health workers are vital and valuable for the people. Objective on Trust findings show that level of trust of community health workers by community members had significant influence to the acceptability of community health workers in the community. The study finding indicates that most of the respondents reported that they were free to discuss any health related issues with the community health workers. Based on study findings, it concluded that CHW's support to community members could play a significant role in building trust between the CHWs and the community in general.

6.2 Recommendations

Based on the results, discussion and conclusions, the following recommendations are given in order to strengthen the health services in the community-by-community health workers.

- **Ministry level recommendations**

In study, it was observed that there is high level of dissatisfaction with the lack of transportation options for use during care provision, which could be potential pitfalls for sustainability of the programme. As efforts, gain momentum to rollout a national cadre of CHWs, improved understanding of CHWs as a heterogeneous group with nuanced needs and varied ambitions is vital for ensuring sustainability of the programme.

It is there of recommended that the ministry level and responsible to consider the work conditions that these CHWs are working.

- **District level recommendations**

Study findings suggest that acceptability of CHWs in Ulanga district for further improved by providing a more holistic combination of financial and nonfinancial incentives and building on existing unselfishness and central needs but also not ignoring financial and other programme inputs. High levels of acceptability could be achieved by strengthening inputs in the programme. The study recommends that the district should ensure increased enrollment of community health workers in order to increase the range of health services within the district.

- **Community level recommendations**

In line with the conclusions, it is recommended that community members need to embrace the role of community health workers towards strengthening of health services in their related areas.

- **Recommendation for further research**

In view of the above-mentioned conclusion and recommendations, the study has created room that calls for further studies on Community Health Workers roles in the community areas. It is therefore recommended that further studies should be conducted on:

i) Redoing study in other areas of the country because these results may not be representative of the accessibility, satisfaction and trust of community health workers in the community in Tanzania.

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APPENDICES

Appendix I: Questionnaire (English Version)

QUESTIONNAIRE ON FACTORS INFLUENCING ACCEPTABILITY OF COMMUNITY HEALTH WORKERS IN ULANGA DISTRICT TO BE ADMINISTERED TO HEADS OF HOUSEHOLDS IN THE COMMUNITY

Questionnaire number ………………………………………..

Date of interview …………………………………………

Name of the district of council …………………………………..

Name of village ………………………………

Social-demographic characteristics. Put a check (√) on the boxes, which indicates your answers

1. How old are you? Age in years ……………………………..

2. Sex

   1) Male

   2) Female

3. Marital status

   1) Single

   2) Married

   3) Cohabiting

   4) Separated/Divorced

   5) Widow/Widower

4. Level of education

   1) Never been to school

   2) Lower Primary education (class 1-4)

   3) Higher Primary education (class 5-7)

4) Secondary education

5) College/university

6) Other (specify)……………………………………..

5. Occupation

1) Not employed

2) Employed in the public sector

3) Employed in the private sector

4) Farmer

5) Petty trader

6) Other (specify)…………………………………….

Objective to determine the accessibility, Trust, and Satisfaction of CHWs in the community to provide service. Put a check (√) on the boxes and fill the blanks inappropriate space which indicates your answers.

By CHWs, who were trained in a nationally recognized institution for one year to work in the community to provide primary health care services?

1. Are there such service providers (CHWs) in this village?

1. Yes

2. No

2. If yes, how many are there?..

3. How many of them do you know by name?…………………….....?

4. Has anyone of them visited your home to provide health care services?

1. Yes

2. No

5. If yes, what kind of service did they provide?

1. Health promotion education
2. Care of sick person in the house
3. To distribute medicines
4. To distribute family planning commodities

6. Are the CHWs available when you need services?

1. No
2. Rarely available
3. Available with difficulty
4. Readily available

7. How many times in the past one year has any one of them visited your household to provide services?

1. Single time in a year
2. Several times in years
3. No even a single time in a year

8. How satisfied were you with the services provided by the CHW at your home?

1. Very satisfied
2. Somehow satisfied
3. Not satisfied at all

9. How many times have you attended community meetings in the past year?......................

10. In those meetings, you attended, did any of the CHWs present in the meeting talk about health issues?

1) Yes
2) No

11. If yes, what topic did he/she talk about?..

12. How clear was the topic to you when it was given by the CHW?

1) Very clear
2) Somehow clear
3) Not clear at all

13. Do you think the number of community health workers in your village is enough?

1. No
2. Yes

14. Are the community health workers in the village resident in the same village?

1. Yes
2. No

15. How many of the existing CHWs were selected by the village government to go for training in a recognized college? Mention………………..

Appendix II:Consent Form (English Version)

Hello, my name is **___________________________** from Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam. As part of a Master of Public Health (MPH) training

Program, research titled, FACTORS INFLUENCING ACCEPTABILITY OF COMMUNITY HEALTH WORKERS IN ULANGA DISTRICT is being done in Ulanga district. The purpose of The study is to determine the availability and level of acceptability of community health workers .in the community and health facility. Ulanga district Morogoro the study is targeting CHWs, Leaders from the community, health facilities, and non-government organizations also community members and health care workers in the health facilities. As one of the participants, you are kindly invited and requested to participate in this study. I would like to request you to answer questions from the questionnaire as truthfully as you can. The questionnaire will take about 15-20 minutes. All the information, which you are going to give, will be confidential. All reports prepared from the study findings and shared with the ministry of health and other stakeholders will not include personal identifying information. Please understand that your participation is voluntary. You may decide not to participate in this study without giving any reasons. However, your input through participation in this study is highly valued and will be appreciated. Your decision not to participate in the study will not in any way hinder you from accessing entitle service at the health facility. There are no potential risks expected for participating in this study. The information that you and others provide will contribute to NACTE and MOHCDEGC

If you have any questions or need further clarifications, do not hesitate to contact the following;

Dastan Andrew –MPH Student (Phone #: O672663524/ 0754064332 email; maigeson@gmail.com)

Supervisor; Prof. Japhet.Killewo

Appendix III: Questionnaire (Swahili Version)

DODOSO KWAAJILI YA KUTAFITI SABABU ZINAZOPELEKEA KUKUBALIKA KWA WAHUDUMU WA AFYA NGAZI YA JAMII WILAYA YA ULANGA.

SEHEMU A: WAKAZII WA MTAA/KIJIJI .

Nambari ya dodoso: ………………………………….

Tarehe ya kudodosa ………………………

Jina la kijiji ulichotoka …………………………………..

Jina la halmashauri ya wilaya……………………..

A: TAARIFA ZA KIDEMOGRAFIA

1. Umri

   1) Chini ya miaka 18
   2) Miaka 18 - 24
   3) Miaka 25-29
   4) Miaka 30 au zaidi

2. Jinsia

   1) Mwanaume
   2) Mwanamke

3. Hali ya ndoa

   1) Hajaoa/Hajaolewa
   2) Ameoa/Ameolewa
   3) Anaishi pamoja na mzazi mwenzie
   4) Ketengana/Kuachana
   5) Mjane

4. Kiwango cha elimu

    1) Hajasoma
    2) Elimu ya msingi
    1) Elimu ya sekondari
    2) Elimu ya chuo

5. Kazi

    1) Hajaajiriwa
    2) Ameajiriwa serikalini
    3) Ameajiriwa sekta binafsi
    4) Mkulima
    5) Mfanyabiashara ndogo ndogo
    6) Mengineyoo

Lengo la (1) kutambua upatikanaji na kiwago cha ukubalikaji wa wahudumu wa afya ngazi ya jamii katika kijiji. (zungushia jibu lako unaombwa)

6. Unamfahamu muhudumu wa afya ngazi ya jamii?

    (a) Ndio
    (b) Hapan

7. Ulishawahi kupata huduma yoyote kutoka kwa muhudumu wa afya ngazi ya Jamii?

    (a) Ndio
    (b) Hapana

8. Unaridhika na huduma zinazotolewa na wahudumu wa afya ngazi ya jamii?

    (a) Yes
    (b) No

9. Je kunawahudumu wa kutosha wa afya ngazi ya jamii katika kijiji chako?

    (a) Ndio
    (b) Hapana

10. Je wahudumu wa afya ngazi ya jamii ni wazawa wa kijijin kwako.

    (a) Ndio

    (b) Hapana

11. Je kunafaida yoyote kuwa na wahudumu wa afya ngazi ya jamii katika makazi yako ?

    (a) Ndio

    (b) Hapan

12. Kama jibu ndio Swali la kumi na moja hapo juu, eleza umuhimu wakuwa nawo na kama jibu hapana eleza kwann hakuna umuhimu na kuwa nawo.

....

....

....

13. Je unatoa ushirikiano wowote kwa wahudumu wa afya ngazi ya jamii.?

    (a) Ndio

    (b) Hapana

14. Kama jibu ndio swali la kumi na tatu hapo juu elezea ni ushirikiano gan uliuonesha na kama hapana eleza kwanini ukupenda kuonesha ushiriko?

....

....

....

Appendix IV: Approval of ethical clearance

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR OF POSTGRADUATE STUDIES

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Telefax: +255-22-2150465
E-mail: dpgs@muhas.ac.tz

Ref. No. HD/MUH/T.506//2018

22nd August, 2019

District Medical Officer
Mahenge District
P.O. Box 22
MAHENGE-ULANGA.

Re: **INTRODUCTION LETTER**

The bearer of this letter Mr. Dastan Andrew is a student at Muhimbili University of Health and Allied Sciences (MUHAS) pursuing MPH-Regular Track.

As part of his studies he intends to do a study titled: ***"Factors incfluencing acceptability of community health workers in Ulanga District".***

The research has been approved by the Chairman of University Senate.

Kindly provide him the necessary assistance to facilitate the conduct of his research.

We thank you for your cooperation.

Ms. Shamila Kamba
For: DIRECTOR, POSTGRADUATE STUDIES

cc: Dean, School of Public Health and Social Sciences
cc: Mr. Dastan Andrew

Appendix V: Introduction Letter

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR OF POSTGRADUATE STUDIES

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Ref. No. DA.287/298/01A/   22nd August, 2019

Mr. Dastan Andrew
Master of Public Health
MUHAS.

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED: "FACTORS INFLUENCING ACCCEPTABILITY OF COMMUNITY HEALTH WORKERS IN ULANGA DISTRICT"

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has, on behalf of the Senate, approved ethical clearance for the above-mentioned study. Hence you may proceed with the planned study.

The ethical clearance is valid for one year only, from **20th August, 2019 to 19th August, 2020.** In case you do not complete data analysis and dissertation report writing by **19th August, 2020,** you will have to apply for renewal of ethical clearance prior to the expiry date.

Dr. Emmanuel Balandya
Ag: DIRECTOR OF POSTGRADUATE STUDIES

cc: Director of Research and Publications
cc: Dean, School of Public Health and Social Sciences, **MUHAS**

HALMASHAURI YA WILAYA YA ULANGA

Simu Na: 023-2620311
Fax No: 023-2620307/311
E-mail: dmomahenge@gmail.com

Idara ya Afya,
S.L.P. 4,
Mahenge/Ulanga.

KUMB: NO: UDC/H/D/18/25

21/08/2019

AFISA MTENDAJI KATA,
KATA YA KICHANGANI,
S.L.P 22,
MAHENGE/ULANGA

YAH; UTAMBULISHO WA KUFANYA UTAFITI.

Husika na kichwa cha habari hapo juu.

Ofisi ya Mganga Mkuu inamtambulisha ndugu **Dastani Andrew** ambaye ni mwanafunzi kutoka Muhimbili University of Health and Allied Science (MUHAS) kufanya utafiti kuhusu *ukubalikaji wa huduma za afya ngazi ya jamii* (**WAJA**) katika kata ya Kichanganyi kijiji cha Idunda.

Utafiti utafanyika kaya **275** za kijiji cha Idunda na vitongoji vyake vyote vitatu pamoja na zahanati moja ya kijiji (vitongoji ni Idunda kati, Ikungua, na Kichangani).

Naomba apewe ushirikiano

Dr. Risasi,A.Rajabu
MGANGA MKUU (W)
ULANGA

DISTRICT MEDICAL OFFICER
P. O. BOX 4
MAHENGE/ULANGA