PERCEIVED QUALITY OF HEALTH CARE SERVICES IN DAR ES SALAAM MUNICIPAL HOSPITALS: COMPARISON BETWEEN CLIENTS USING USER FEES AND NATIONAL HEALTH INSURACE FUND.

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH OF THE UNIVERSITY OF DAR-ES-SALAAM

2005.

CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by the University of Dar es Salaam a dissertation entitled: PERCEIVED QUALITY OF HEALTH CARE SERVICES IN DAR ES SALAAM MUNICIPAL HOSPITALS: COMPARISON BETWEEN CLIENTS USING USER FEES AND NATIONAL HEALTH INSURANCE FUND. In partial fulfillment of the requirements for the degree of the Master of Public Health of the University of Dar es Salaam.

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DECLARATION

I, Salama Jacob Mwakisu, 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.

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DEDICATION

I dedicate this work to my lovely husband Shaaban Mwatawala, my daughter Sabrina and my son Raheem who missed my love during the busy times of my studies.

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ABSTRACT

A cross sectional study was conducted in Dar es Salaam Municipal hospitals in the month June 2005, with the main objective of comparing perceived quality of health care services, amongst clients using user fees and National Health insurance Fund. A total of 563 exit interviews were conducted, of which, 281 were with clients using user fees and 282 were with NHIF members. Respondents were selected using convenience sampling method. A Structured questionnaire and facility checklists were used to collect data.

The study findings show that provider client interaction was perceived to be good, with a higher proportion of NHIF clients (93.6%) compared to clients paying user fees (88.3%) reporting to have spent adequate consultation time with the prescriber ($P<0.05$), and almost similar proportions of respondents paying user fee and NHIF reporting to have been given adequate explanation about their health problems (i.e. 74.4% and 75.5% respectively) and that they had received adequate instructions on the use of prescribed drugs (i.e. 97.2% Versus 97.3% respectively). The study findings also show that Overall, 28.4% of the clients interviewed reported that were physically examined, with about 30% of clients paying user fees reporting lack of enough privacy. Majority of the clients (81.5%) interviewed were satisfied with physical state of buildings and attitude of health worker (i.e. 85.1% user fees versus 86% NHIF) at the facilities that they had attended. The respondents were also interviewed on aspect of duration of time spent waiting to get health care. Less than a quarter of clients interviewed perceived waiting time to be short, with significantly higher proportion of clients paying user fees (21.4%) compared to

NHIF (13.5%) clients perceived waiting time as being short. Drug availability was reported to be a problem in this study, where more than two thirds (71.2%) of the client responded that drugs were not always available at the facilities they attended.

The level of satisfaction with the quality of health care services was high (84.4 %) among clients interviewed, with a small proportion (15.6%) being dissatisfied mainly due to long waiting time (72.7%) and lack of drugs (64.8%). In order to improve quality of health services clients suggested that waiting time should be reduced, drugs availability, attitude of health care provider, physical state of facility buildings and cleanliness of surroundings should be improved. The author recommends that clients' opinions be in cooperated in the strategies planned to improve quality of health care services

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LIST OF ABBREVIATIONS

CHF	Community Health Fund
DSM	Dar es Salaam
IMF	International Monetary Fund
MoH	Ministry of Health
MPH	Master of Public Health.
NHIF	National Health Insurance Fund
SAP	Structural Adjustment Programmes
UNICEF	United Nations Children's Fund
VOL	Volume
WB	World Bank
WHO	World Health Organization

CHAPTER ONE

1.0. INTRODUCTION

1.1. BACKGROUND

"The concept of quality of health care services is multidimensional; it does not apply to all situations equally" (De Geyndt, 1995). Quality can be defined in various ways, one commonly used definition of quality of health care services is: "doing the right thing, right, right away" (MoH, 2000). Good quality of health care can also be defined as the one that meets technical standards as well as the needs and expectations of users and community (MoH, 2000).

From health service providers' perspective, quality care implies that he or she has skills, resources and conditions necessary to improve the health status of the patient and community, according to the technical standards and available resources (Brawley, 2000). To the clients, perceived good quality of care means something different from that perceived by health planners and health professionals. For the clients' perceived good quality health care is the one that meets their perceived needs and expectations (Brawley, 2000). Even though the judgment made by clients may be different from what professionals may judge to be the best for them, assessment of quality of care through clients' perceptions is increasingly being used to reflect quality of health care in relation to structure, process and outcome (Baltussen et al., 2001).

Immediately after independence the Government of Tanzania started to provide free health care services to all its citizens with a major aim of attaining equity in health care consumption (MoH, 1994). However, the economic crisis in the mid 1970s, increase in population growth, change in disease pattern and escalating cost of disease management, eroded the government's ability to continue to provide free health services, resulting into under funding of public health facilities at all levels (MoH, 1996). Inadequate funding of the public health sector led to problems of low morale of health staff due to low wages, frequent drug shortages, lack of essential equipment and supplies and overall deterioration of the health infrastructure (MoH, 1994).

The introduction of alternative health financing mechanisms such as user fees, Community Health Funds (CHF) and National Health Insurance Fund (NHIF) was viewed as means of generating additional revenue for the health sector, improving quality of health care services, as well as promoting equity, accessibility and efficiency in the use of health services in Tanzania (MoH, 1997). Alternative financing mechanisms also aimed at ensuring that communities participate in contributing to some of the cost of provision of health services they receive at the government health facilities through direct payment or risk pooling mechanisms (MoH, 1994).

User fees were the first alternative health financing mechanism adopted in Tanzania, and it was introduced in 1993. Its implementation was done in phases, starting with referral hospitals and regional hospitals, followed by district hospitals, thereafter in health

centers and finally dispensaries (MoH, 1999). Introduction of user fees in government health facilities provided a challenge to most Tanzanians, regarding their entitlement to medical benefits. This was because the universal health insurance coverage through taxation was removed, and there was no longer free medical services offered to the government employees and other citizens in government health facilities. This accelerated the need for introduction of health insurance schemes for people employed in the public sector (MoH, 1997). The National Health Insurance Fund was first implemented in 2001, the initial coverage has been limited to employees in the public sector and it will gradually be extended to private sector employees as well. The scheme is compulsory in nature and the contribution rate is 6%, of which the employee contributes 3%, and the employer contributes the other 3%. It has predetermined package of benefits and does not cover anything that is not stipulated in the package (NHIF ACT, 1999).

Another health financing mechanism that is implemented in Tanzania is the Community Health Fund (CHF), which was first piloted in Igunga district in 1996 and it is intended to benefit people in the informal sector (MoH, 1997). This is a risk pooling mechanism where households are supposed to contribute a fixed amount once a year, so that they can be covered for the whole year. The government then allocates matching funds (MoH, 1997).

Currently, in Dar es Salaam Municipal hospitals, people access health care by making direct out of pocket payments (User fees) or pay indirectly through the NHIF, while others are exempted for various reasons. This study aimed at comparing perceived quality of health care services amongst clients using user fees and NHIF as health financing options in health facilities in Dar es Salaam Municipalities.

1.2. STATEMENT OF THE PROBLEM

Deterioration of the quality of care in public health facilities has been a critical issue in Tanzania (MoH, 1999). In order to enhance performance of the health care delivery system the government of Tanzania adopted health sector reforms in early 1990s, with the introduction of alternative health financing mechanisms being one of its elements (MoH, 1999). The objectives of the financial reforms were; to raise additional revenue, improve quality, equity and accessibility to health care services and to promote the efficient use of public health care facilities (MoH, 1994).

User fees were the first alternative health financing mechanism to be introduced in Dar es Salaam district hospitals in 1993 (MoH, 1999), followed by implementation of National Health Insurance Fund in 2001, covering all formal sector employees (NHIF, 2003). Following the introduction of National Health Insurance, public health care facilities in Dar es Salaam started to provide health care services to clients who pay for their health care consumption using User fees and NHIF. Several studies have been done to assess the impact of the introduction of alternative health financing mechanisms in the health sector specifically on access and quality of health services. However most of these studies have focused on the impact of the introduction of user fees. The results from these studies have shown that the perceived quality of health care services in public health facilities is still poor (Maier and Urrasa, 1997; Shayo, 2002; Mallya, 2004) and there is little information on perceived quality among clients who are members of National Health Insurance Fund. The author is also not aware of any study that has

compared perceived quality of health care services in public health facilities among clients using the same facility but under different health financing options.

1.3. RATIONALE OF THE STUDY

Patients are not only consumers of health services, but they also play a part in contributing financial resources used in the running of health services. Assessing clients' perceptions on the quality of care will give them an opportunity to express their opinions on the quality of services that they have received and whether their expectations on quality are being met.

The information obtained from this study will help to inform the policy makers and health care providers about the quality of health care services as perceived by users. This will enable them to develop and implement appropriate strategies aimed at improving quality of health care services provided in Dar es Salaam Municipal hospitals.

1.4. RESEARCH QUESTIONS

1. What are the perceptions of user fees and NHIF clients on quality of health care services provided in Dar es Salaam Municipal hospitals?
2. Are the clients satisfied with the quality of health care services provided?
3. How can the quality of health care services in Dar es Salaam Municipal hospitals (as perceived by clients) be improved?

1.5. OBJECTIVES

1.5.1. Broad Objective

To assess perceived quality of health care services among clients using user fees and National Health Insurance Fund in Dar es Salaam Municipal Hospitals.

1.5.2 Specific Objectives.

1. To establish clients' opinions on client-provider interactions during service provision.
2. To establish clients' perceptions on drug availability by health financing option used.
3. To establish clients' perceptions on waiting time spent to get health care by health financing option used.
4. To establish clients' perceptions on the physical state of buildings of the Municipal hospitals.
5. To determine the proportion of clients who were satisfied with the quality of health services by health financing option used.
6. To establish reasons for clients' satisfaction or dissatisfaction with the quality of health care services by health financing option used.
7. To elicit clients' opinions on how to improve the quality of health care services Provided in Dar es Salaam Municipal hospitals.

1.6. LITERATURE REVIEW

1.6.1 Health Sector Reforms and The Quality of Health Care Services.

Health sector reforms are currently taking place in many developing countries in order to address problems of chronic inefficiency, low accessibility and poor quality of health services and growing concern of financial sustainability. The driving forces behind health sector reforms were the economic crisis, which occurred in the late 1970s and early 1980s due to tremendous increase in oil prices, rising interest rates of external debts and falling prices of other commodities, leaving African countries unable to repay mounting foreign depts (Colgan, 2002). In order to solve the problem of economic crisis, African countries and other developing countries signed an agreement with the World Bank and IMF to adopt structural adjustment programmes (SAP), which recommended cutbacks in government expenditure on health sector and other social services (World Bank, 1993).

The dramatic drop in health expenditure in the 1980s and 1990s in the developing countries, led to fall down of the economic and social progress attained in the previous two decades, which were characterized by increased number of health professionals employed in public sector, improved health care infrastructure and extension of health care to formerly unserved areas (World Bank, 1993). For example before SAP were implemented the government of Tanzania succeeded in expanding access to health care nationwide. By 1977, more than three quarters of Tanzania's population lived within

5km of a health facility. But after SAP under funding in the health sector occurred which leading to poor performance (Yudkin, 1999).

In order to generate resources for under funded health sector and encourage better quality and more efficient health care system, the World Bank Agenda for reforms was launched, as well as the promotion of the Bamako initiative of 1987 by UNICEF and World Health Organization. In its agenda for reform, the World Bank emphasized the need for introduction of cost recovery strategies (World Bank, 1993). This included introduction of user fees for health services that were previously provided free of charge and promotion of Health Insurance Schemes or prepayment schemes (Green, 1992; World Bank, 1993). The objectives of the Bamako initiative were to improve quality of services and ensure equity in access of care through community participation in form of payments for drugs and development of community management capacity (Russell and Gilson, 1997).

In response to World Bank recommendations to adopt cost recovery and the Bamako initiative, various countries in sub Saharan Africa and the rest of developing countries had introduced user fees into their health sector by the mid-1990s. A survey done by the World Bank in 1993 reported that out of 37 African countries, 33 of them had cost recovery policies for the public sector (Nolan and Turbat, 1995). Although in public health facilities user fees were introduced in the last decade, they have been used by private and voluntary owned organizations in most developing countries since a long

time ago, even before the World Banks' recommendation to adopt cost recovery in health services (Shaw, 1995).

Experience shows that alternative health care financing schemes can succeed in achieving their goals only if governments take complementary measure to ensure that services are accessible to all people and are of reasonable quality and that the generated revenue is properly managed and reinvested to improve the quality of health care services. However, studies show that these conditions are rarely met in practice. For example it has been revealed that, in some cases user fees revenue has not been retained within the health sector, but goes to other local uses (Laterveer, et al., 2004; Gilson, 2001).

The biggest concern after the introduction of user fees in previously free of charge government health facilities has been the possibility of denying the poor from accessing modern health care services (Abel-Smith and Rawal, 1992; Russell and Gilson, 1997). Review of studies show that introduction of user fees is often followed by a subsequent decrease in service utilization in many developing countries (Haddad and Fournier, 1995; Bennet and Gilson et al., 2000), and that the most affected people are the clients who either have low income or those needing to make multiple visits to the health facilities (Yolder, 1989). For example, a study done in Tanzania showed that utilization of Outpatient services declined by 53.4% after user fees were introduced (Hussein and Mujinja, 1997). In order to protect the most vulnerable groups several countries

including Tanzania have introduced exemption mechanisms for very poor people, pregnant women, children under five, the patients with chronic diseases such as diabetes and those with severe health conditions such as TB, and AIDS (Bitran and Giedion, 2001, Gilson, 1997).

Currently, the focus of international debate is on the need to move away from out of pocket payment as a source of health financing towards Health Insurance Schemes. The types of health insurances suggested by international organizations include; Social Health Insurance Schemes in which contributions are based on the payroll deductions, with employee and employer contributing to the premium set. The scheme is compulsory in nature. Another type of health insurance schemes is Community Based Health Insurance. This is not linked to the employment status but premiums are commonly set according to risk faced by average number of the community. Enrollment in these schemes is voluntary in nature. There are also Private Insurance Schemes where people pay premiums related to expected cost of providing services to beneficiaries. In this type people in high risk pay more than those at low risk (Bennet and Gilson, 2001). However, in developing countries Health Insurance Schemes are still confined to a minority of population and only few countries have considerable experience in setting up micro-health insurance. These include Burkina Faso, Ghana, Mali and Senegal (Jutting, 2001). In Tanzania the first health financing option to be introduced has been user fees, adopted in 1993, followed by Community Health Fund which was piloted in

1996 and recently National Health Insurance Fund was introduced whose implementation began in 2001.

Following introduction of alternative health financing mechanisms, measurement of quality of care in governmental health facilities has received a great attention in Sub Saharan Africa. This is based on assumption that introduction of cost sharing in the previously free health services can only be successful and acceptable if quality of health care is also improved at the same time (Litvack and Bodart, 1993). Studies show that the quality of health care can influence choice of health facility to use and it can also affect individual willingness to pay for health care services (Mujinja and Mabala, 1992; Litvack and Bodart, 1993). This was proved in the opinion polls, which were done in Tanzania before introduction of user fees, where it was shown that 87% of the participants were willing to pay for health sevices on condition that health care services were of good quality (Mujinja and Mabala, 1992).

1.6.2 Quality of Health Care Services.

Although there is no single common definition of quality the most widely used conceptual framework for assessing quality, is the one introduced by Donabedian (1997), which uses the elements of structure, process and outcome. Structure attributes (also sometimes referred to as input) include the setting in which care occurs. Structural aspect of quality includes, physical state of buildings (which include adequacy and condition), availability of equipments, drugs and supplies, range of service available,

number and qualification of staff, and other organizational activities (Gilson, 1992). However, availability of drugs at health facilities is usually perceived as the most important measure of quality in many communities, though this may be different in some communities (Msamanga et al., 1996). For example a study done in Zambia showed that people criticized cost sharing because it did not improve the quality of health care services in terms of drug availability (Van Der Geest, 2000). Another study done to assess perceived quality of care in primary health care services in Burkina Faso also showed that despite introduction of alternative health financing mechanisms, clients were not satisfied with the adequacy of resources and services, particularly the availability of drugs (Baltussen et al., 2001). In Cameroon, it was also found that, utilization of services in public health facilities had increased significantly after introduction of user fees and this was due to improved quality of health services specifically availability of drugs (Litvack and Bodart, 1993).

In a study done in Bagamoyo district of Tanzania, 63.6% of patients interviwed reported that despite the introduction of user fees shortage of drugs was one of main problems that affects quality of health care (Mallya, 2004). A similar situation was reported in Tanga, where it was observed that 23.6% of patients interviewed were not satisfied with the quality of health care services because they could not get all the drugs required as they were not available in public health facilities (Maier and Urrasa, 1997).

Another element of structural aspect of quality that determines client perceived quality of health care is the physical state of health facility buildings. In a study done in Bagamoyo district, 65.4% of the clients interviewed reported that the introduction of user fees had little positive impact on the state of hospital buildings in terms of cleanliness and maintenance of buildings (Mallya, 2004). In the study done in Tanga it was also observed that some of the buildings had collapsed due to lack of regular maintenance (Maier and Urrasa, 1997).

In most instances structural aspect of quality of care have been evaluated in terms of physical conditions of facility buildings and availability of adequate equipment and drugs. However the organization aspect such as number of staff, qualification of staff, administrative and managerial procedures are also important. This is due to the fact that poor quality of the health care services can also be contributed by bad performance of health workers due to the lack of knowledge, inability to translate sufficient knowledge acquired through training into appropriate attitudes and performance, and low staff morale and motivation caused by low salary and poor working environment (Schopper, 2001).

Assessment of performance of health workers in the three provinces of Angola showed that only 12% of more than 500 consultants observed were judged to be performing well in terms of proper diagnosis, treatment given and information provided. A study done in

Dar es Salaam Tanzania also showed that more than one third of all consultations were associated with serious diagnostic error (Kanji et al., 1995).

Process is another aspect of quality. It refers to all the activities associated with providing and receiving care, and include technical competence of service providers, interpersonal skills, maintenance of privacy and confidentiality (Donabedian, 1980). The technical aspect of quality refers to how well medical science and knowledge are applied to the diagnosis and treatment of medical problems (Donabedian, 1980). Beyond technical aspect, interpersonal aspect of quality of health care service is an essential part of the process of health care provision. It refers to interactions between client and provider, in which friendliness, attentiveness of health care providers and effective communication skills has critical impact on client satisfaction with the quality of health care services (Donabedian, 1980).

In a study done in Zaire, clients were asked to give two best qualities of a health care providers, the first mentioned quality was communication aspect (based on respect and friendliness), followed by technical skills (Haddad and Fournier, 1995) Studies also show that, in some countries, lack of respect for patients and possible abusive language of health workers towards patients is a problem even after the introduction of alternative financing mechanisms (Baltussen et al., 2000; Van Der Geest, 2002). This was also established in study done in Tanga where it was observed that perceived poor attitude of health workers was a problem. Clients complained of unfriendly attitudes and harsh

language on part of nurses (Maier and Urrasa, 1997). However, provider client interaction does not only involve attitude of health workers but also the process of interaction, such as whether physical examination was done, privacy maintained during physical examination, adequacy in consultation time and information sharing. In most of primary health care facilities, privacy has been reported to be poor due to inadequate space for counseling and examination (MoH, 2001)

Outcome is another important measure of quality of health care services. It includes the changes in the health status (e.g. TB cured, controlled blood pressure), the improved quality of life and clients' satisfaction achieved through inputs and processes of care (Donabedian, 1997). However, changes in health outcome have proven to be difficult to measure, instead many studies have used client satisfaction as an important measure of outcome aspect of quality of care (Van Der Geest, 2000).

Clients' satisfaction occurs when services experienced, meet clients' expectations (Smith and Englebrecht, 2001). To the large extent it is related to aspects that are not strictly medical or technical, but mainly on interpersonal aspects. (Mwabu et al., 1993; Akin et al., 1995). A study done by Msamanga et al, 1996 in Mara and Kilimanjaro, showed high level of perceived clients' satisfaction was based on waiting and consultation time, provider-client interaction and interpersonal relations.

Many studies have been done to assess impact of user fees on the quality of health care services. However, there is still mixed evidence from African countries that user fees contribute to the improvement of quality of health care. In some countries evidence indicates that fees improved quality of care and patients attendance in the public health facilities, while in other areas user fees are reported to have caused decreased utilization of health care services (Litvack and Bodart, 1993). Assessment of equity implication of health sector user fees in Tanzania found that there is limited positive evidence that user fees have in general achieved their objectives of sustainability, drug availability, quality of care, equity and access to the poor. (Laterveer et al., 2004). On the other hand, members of the NHIF have also shown concerns on poor patient-providers interactions, long waiting times and non-availability of drugs as the main problems which have led to low satisfaction with quality of health care services (NHIF, 2003).

In this study the various structures, process and outcome attributes have been used to compare the perceptions of clients who use different health financing options on the quality of health care services provided in Dar es Salaam Municipal hospitals.

CHAPTER TWO

2.0. STUDY METHODOLOGY

2.1. Study Area

The study was conducted in Dar es Salaam, which is the largest city in Tanzania and also the main business center in the country. The City is located along the Indian Ocean Coast and is bordered by the Coast region on the West and North, and by Lindi region on the South. Its population is estimated to be around 2.5 million of whom 1.3 million inhabitants are males and 1.2 million are females (National Census, 2002). The average household size is 4.2 and the annual population growth rate is 4.3%.

The City is divided administratively into three Municipalities, which are Mwananyamala, Amana and Temeke, and is harbored by a mixture of people belonging to different ethnic tribes of Tanzania, Tanzanians of Indians, Arabic and European origin, as well as foreigners. The health care delivery system in Dar es Salaam comprises of a formal sector as well as an informal health sector. The formal sector includes private and public health facilities. Public health facilities include Muhimbili National hospital, specialized hospitals (Ocean Road Cancer Institute and Muhimbili Orthopedics Institute), Municipal hospitals (Mwananyamala, Temeke and Amana hospital), Health centers and dispensaries. There is also the Lugalo Military hospital, which also serves the general population. Public health facilities include 4 hospitals, 5 health centers and 57 dispensaries. Private health facilities include 7 hospitals and 22 dispensaries.

Number and type of Health facilities as per health statistics abstract MoH (1995)).

Type of facility	Government	Voluntary	Parastatal	Private	Total
Hospital	4	-	2	7	13
Health centers	5	-	1	-	6
Dispensary	57	36	46	22	161

2.2. Study Design

This was a cross sectional study, which was conducted in Dar es Salaam Municipal hospitals in the month of June 2005.

2.3. Study Population

The study population consisted of clients attending Municipal hospitals in Dar es Salaam who paid for health services that they had received through user fees or through the NHIF.

2.4. Sample Size Determination

The following formula was used to determine the sample size:

$n = (Z_{A/2} + Z_B)^2 [P_1(1-P_1) + P_2(1-P_2)]/(P_1-P_2)^2$

Where n is the sample size for each group.

Z_A is the standard normal deviate at 0.025, which is equal to 1.96.

Z_B is the standard normal deviate when power is 80%, which is equal to 0.84.

P_1 is the proportion of clients paying User fees estimated to be satisfied with the quality of health care services, which in this study is taken to be 84% (Mallya, 2004).

P_2 is the proportion of NHIF clients estimated to be satisfied with quality of health care services. For this study it is assumed to be 74%.

$n = (1.96 + 0.84)^2[84(100-84) + 74(100-74)]/(84-74)^2 = 256$

When the above figures were substituted in the formula, the figure of 256 was obtained for each group. The minimum sample size of clients to be interviewed was therefore 512. However, taking 10% non response rate, a total of 563 respondents were interviewed, 281 who paid for the health care services through user fees and 282 clients who paid through NHIF.

2.5. Sampling Procedures

Selection of study site

Selection of the study site was purposively done. Dar es Salaam was selected due to financial and time constraints.

Selection of study population

Convenience sampling method was used to obtain clients for exit interviews. Client leaving a Municipal hospital, after receiving health care services was approached for interview. A total of 563 clients were interviewed, of whom 188, 187, 188 clients from Amana, Temeke and Mwananyamala hospital respectively



Inclusion criteria

-Only clients who paid for services using user fees and NHIF were interviewed.

-Adults (clients aged 18 years and above).

Exclusion criteria

-Exempted clients.

-Clients who paid using health financing options other than user fees / NHIF.

-Clients aged below 18 years of age.

2.6. Data Collection Procedures.

Data was collected daily from 8.00am to 4.00pm, except for weekends, for a period of three weeks. The data collection instruments were a facility checklist and structured-interview questionnaire with open and closed ended questions.

The author collected data with the help of three research assistants who were selected based on the following criteria; having attained a minimum of secondary ordinary level education and fluency in both (written and spoken) Kiswahili and English. The research assistants were informed on the objectives of the study, and were trained on how to use the data collection instruments and on how to communicate with clients before starting the data collection process.

The research team interviewed a total of 563 clients attending the Outpatient departments of the three Municipal hospitals and who had finished getting services and was ready to go home. Clients were asked to provide the following information: socio-demographic characteristics (age, sex, marital status, education level and occupation), perceived duration of time waiting to be attended by provider, drug availability, provider-client interactions, physical state of hospital buildings and cleanliness of the surroundings as well as overall satisfaction with services provided. The questionnaire used was originally prepared in English, however a Kiswahili version was used in the field (See appendices II and V). The questionnaire was pre tested to check for validity and reliability of the instrument, before using it for data collection in the field.

A facility checklist was also used to collect data on availability of drugs and equipments/supplies, number and cadre of human resources available, physical state of buildings and cleanliness of the surroundings. (See appendix III). The source of information for filling the checklist was through staff interviews and going through relevant hospital inventories.

2.7. Data Management and Analysis.

The data collection tools were checked every evening by the researcher to find out if they have been filled correctly and completely.

The data obtained was coded manually and entered into computer using Epi- info Computer program version 6.04. The researcher validated and analyzed data using the same program. The analysis was done using two by two contingency tables, which were prepared based on the specific objectives. The significance of differences observed were measured using the Chi-square test and p-value of <0.05.

The variables, which were analyzed, include social demographic characteristics (age, sex, education level, marital status and occupation). Perceived waiting time, availability of drugs, state of buildings and cleanliness, provider clients interactions, and the general satisfaction with perceived quality of health care services.

2.8. Study Limitations

- The study did not involve direct observation of health service provision; instead the study was based on interpersonal aspects of quality through clients' perceptions.
- The study could not assess the change of health status of clients after receiving health care; extent of clients' satisfaction was assessed as measure of outcome aspect of quality of health care services.
- The respondents could have given what they considered to be socially acceptable answers especially if they believed that unfavorable comments could negatively affect the service they will receive in the future.

2.9. Ethical Clearance

Clearance was obtained from MUCHS Research and Publication Committee. Permission to conduct the study in the Municipal hospitals was obtained from the Dar es Salaam City Administrative Secretary.

Informed consent was sought from clients before the interview began. Clients were informed about the purpose of the study and that participation was voluntary. Clients were also informed about anonymity that is their names would not appear on the questionnaires and that any information they gave will remain strictly confidential and will only be used for research purpose. Clients were included in the study upon accepting to participate.

2.10. Definition of Terms Used

User Fees

These are prices charged to the clients in order for them to obtain a certain level of health care, which is not necessarily equivalent to the cost of the health services delivered to him/her.

National Health Insurance

Is a way of paying for some of the cost of health cares. This is a prepayment mechanism for health care consumption, protecting insured individuals and their beneficiaries from paying high treatment cost in the event of sickness.

Equity

Access to the health services according to the people's needs.

Structural Adjustment Programmes

These were economic reform programmes, introduced by the World Bank and IMF in the late 1980s to rebalance budgets and deal with the build up of national debts.

Health Sector Reforms

A sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population (MoH, 1997).

Willingness to Pay

The maximum amount of money an individual is willing to give up to obtain certain level of health services, at a given time period.

Exemption Mechanisms

Government policies or guidelines that reduce the amount to be paid or completely exempt from full cost of user fees, thus protecting these individuals from the burden of fees charged at government facilities.

Essential Drugs

Essential drugs are those that satisfy the priority health care needs of the population (Hogerzeil, 2002).

CHAPTER THREE

3.0. RESULTS

CLIENT EXIT INTERVIEW

A total of 563 outpatients attending Municipal hospitals in Dar es Salaam were interviewed, of whom 281 (49.9%) were clients paying user fees and 282 (50.1%) were NHIF clients (See Table 1).

Table 1: Distribution of clients interviewed by Municipal hospital attended.

Name of facility	User Fees (n =281)		NHIF (n=282)		Total (n=563)	
	N	(%)	n	(%)	n	(%)
Amana	95	(33.8)	93	(33.0)	188	(33.4)
Temeke	92	(32.7)	95	(33.7)	187	(33.2)
Mwananyamala	94	(33.5)	94	(33.3)	188	(33.4)

Table 2 shows that, a higher proportion of the study sample was females (63.8%). Most of the clients were either married (43%), or single (34.6%). Clients who were divorced/separated constituted the lowest proportion (2.5%). About 40% of the clients interviewed were in the age group of 20-29, those aged below 20 years contributed only 7.3% of the total respondents.

Respondent in the primary (246) and secondary (197) education categories formed the majority (78.9%) of the study sample. Table 2 also shows that the highest proportion of respondents paying user fees were in the primary education category, while the highest proportion of respondents using NHIF were in the secondary education category i.e. 61.4% and 46.5% respectively.

Table 2: Socio-demographic characteristics of outpatient clients interviewed

Characteristics	User Fees (n =281)		NHIF (n =282)		Total (n =563)	
	N	(%)	n	(%)	n	(%)
Sex						
Male	100	(35.6)	104	(36.9)	204	(36.2)
Female	181	(64.4)	178	(63.1)	359	(63.8)
Age group (years)						
< 20 years	19	(6.8)	22	(7.8)	41	(7.3)
20-29 years	126	(44.8)	97	(34.4)	223	(39.6)
30-39	77	(27.4)	84	(29.8)	161	(28.6)
> 40	59	(21.0)	79	(28.0)	138	(24.5)
Marital status						
Single	89	(31.7)	106	(37.6)	195	(34.6)
Married	123	(43.8)	119	(42.2)	242	(43.0)
Cohabited	51	(18.1)	42	(14.2)	93	(16.5)
Divorced/Separated	7	(2.5)	4	(1.4)	11	(2.0)
Widow/Widower	11	(3.9)	11	(3.9)	22	(3.9)
Educational status						
No formal education	22	(7.9)	4	(1.4)	26	(4.6)
Adult education	8	(2.9)	5	(1.8)	13	(2.3)
Primary education	172	(61.4)	74	(26.2)	246	(43.8)
Secondary education	66	(23.6)	131	(46.5)	197	(35.1)
Post secondary education	12	(4.2)	68	(24.1)	80	(14.20

NB: One user fee client did not respond

Respondents were asked to give reasons why they decided to get health care services at the facility that they had attended (see table 3). Overall 51.1% of the respondents mentioned short distance as the main reason for seeking care at the Municipal hospitals they attended, while 40.9% mentioned that it was because of the good quality of health care services that were provided. Almost a similar proportion of clients using user fees and NHIF clients mentioned short distance to the health facilities and good quality of health care services to be the reasons for choice of health facility that is 50.5% versus 51.8% and 40.6% versus 41.2% respectively. A slightly higher proportion of clients using user fees compared to NHIF clients, mentioned referral to be the reason for choice of health facility (5.0% versus 3.5% respectively).

Table 3: Reasons for choice of health facility by health financing option used

Reasons for choice	**User Fees (n=281)**		**NHIF (n=282)**		**Total (n=563l)**	
	n	**(%)**	**n**	**(%**	**n**	**(%)**
Close to where I live	142	(50.5)	146	(51.8)	288	(51.1)
Good quality of care	114	(40.6)	116	(41.2)	230	(40.9)
I was given a referral to come here	14	(5.0)	10	(3.5)	24	(4.3)
Directed by a friend/Relative	11	(3.9)	10	(3.5)	21	(3.7)

From table 4 it is seen that a larger proportion of clients who attended the Dar es Salaam Municipal hospitals, were more likely to use public transport (70.2%), followed by those who walked (25.9%) compared to other means of transport. Table 4 also shows that a higher proportion of NHIF clients use public transport (75.9%) compared to those paying user fees (64.4%), while a higher proportion of clients using user fees (31.3%) compared to NHIF clients (20.6%), reported to have walked to the facilities they attended.

Table 4: Mode of transport used by clients attending Municipal hospitals by health financing option used

Mode of transport	User Fees (n=281)		NHIF (n=282)		Total (n=563)	
	n	(%)	n	(%)	n	(%)
Public transport	181	(64.4)	214	(75.9)	395	(70.2)
On foot	88	(31.3)	58	(20.6)	146	(25.9)
Taxi	10	(3.6)	9	(3.2)	19	(3.4)
Bicycle	2	(0.7)	1	(0.4)	3	(0.5)

Table 5 shows that, overall 71.6% of interviewed clients reported drugs were not always available at the Municipal hospitals they attended, while a small proportion (1.4%) said that drugs were never available. Analysis of perception on drug availability by health financing option used shows that, a higher proportion of NHIF clients (73.8%) compared to those using user fees (69.4%) responded that drugs were sometimes available. On the other hand a higher proportion of clients using user fees reported that drugs were never available compared to those using NHIF i.e. 2.1% and 0.7% respectively. However, the number of respondents was small, 6 and 2, respectively. Less than a quarter of the clients interviewed (21.5%) reported that drugs were always available. About 6% of the respondents were not regular users of the health facilities and could not comment on drug availability.

Table 5: Clients' perception on drug availability by health financing option used

Clients perception	**User Fees (n=281)**		**NHIF (n=282)**		**Total (n=563)**	
	n	**(%)**	**n**	**(%)**	**n**	**(%)**
Always available	58	(20.6)	63	(22.3)	121	(21.5)
Sometimes available	195	(69.4)	208	(73.8)	403	(71.6)
Never available	6	(2.1)	2	(0.7)	8	(1.4)
Cannot tell	22	(7.8)	9	(3.2)	31	(5.5)

P=0.04 Chi square=8.08 Degrees of freedom=3

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Sometimes available	195	(69.4)	208	(73.8)	403	(71.6)
Never available	6	(2.1)	2	(0.7)	8	(1.4)
Cannot tell	22	(7.8)	9	(3.2)	31	(5.5)

P=0.04 Chi square=8.08 Degrees of freedom=3

Clients' opinions on provider-client interactions were assessed in the following areas: Health workers' attitude towards patients, adequacy of consultation time and information exchange during consultation (See tables 6-8). Overall (86%) of the interviewed clients responded that they were satisfied with the attitude of health workers at the three Municipal hospitals. About 14.0% of the clients perceived that the attitude of health workers towards them as being poor, with a higher proportion of clients using user fees (14.9%) reporting this compared to NHIF clients (13.1%). However, this finding is not statistically significant ($p>0.05$).

Table 6: Clients perception on health workers' attitude by health financing option used

Perceptions	User Fees (n=281)		NHIF (n=282)		Total (n=563)	
	n	(%)	n	(%)	n	(%)
Very satisfactory	23	(8.2)	32	(11.3)	55	(9.8)
Satisfactory	216	(76.9)	213	(75.5)	429	(76.2)
Poor	42	(14.9)	37	(13.2)	79	(14.0)

P=0.40 Chi square =1.81 Degrees of freedom=2

Clients were asked to give their opinions on perceived adequacy of the time they had spent with the health care provider to discuss their health problems. Overall 91% responded that they had been given adequate consultation time. However, a higher proportion of NHIF clients (93.6%) compared to clients using user fees (88.3%) reported that consultation time was adequate. This finding was statistically significant (P<0.05).

Table 7: Clients opinions on adequacy of consultation time by health financing option used

Consultation time	User Fees (n =281)		NHIF (n =282)		Total (n =563)	
	n	(%)	n	(%)	n	(%)
Adequate	248	(88.3)	264	(93.6)	512	(90.9)
Inadequate	33	(11.7)	18	(6.4)	51	(9.1)

P=0.027 Mantel-Haenszel Chi-square=4.90

When clients were asked if the health care providers who had attended them gave them adequate explanations about their health problems, three quarters (75%) of the clients interviewed responded positively (See table 8). The proportion of clients using user fees and NHIF clients who responded positively were almost similar, that is 74.4% and 75.5% respectively. Table 8 also shows that 68.3% of the clients reported that they were given counseling advice about their health problems. Analysis by health financing

option showed that there were no significant difference between clients using user fees and those using NHIF ($p>0.05$).

The majority of the clients (97.2%) responded that they had received adequate instructions on how to use drugs that were prescribed for them. Similar proportions of clients who paid user fees and those who were NHIF members/beneficiaries reported that they had received adequate instructions on the use of prescribed drugs, that is 97.2% and 97.3% respectively.

Table 8: Information given to the clients by health financing option used

Type of information	User Fees		NHIF		Total	
	n	(%)	n	(%)	n	(%)
Adequate explanation of health Problems provided	209	(74.4)	213	(75.5)	412	(75.0)
Counseling advice provided	190	(68.1)	189	(68.5)	379	(68.3)
Adequate instructions on how to use prescribed drugs provided	245	(97.2)	248	(97.3)	493	(97.2)

Results show that, only 160 (28.4%) of the clients interviewed reported that they were physically examined at the health facilities they attended. There is very slight difference in the proportion of clients using user fees and those using NHIF who reported that they were physically examined i.e. 28.1% and 28.9% respectively. The difference is not statistically significant ($p>0.05$). Table 9 shows that overall, 85.6% of the clients who

were physically examined reported that there was privacy during physical examination. All NHIF clients responded positively on the maintenance of privacy during physical examination, compared to 29.9% of clients paying user fees who responded negatively ($p<0.05$). When asked to give reasons for the lack of privacy, all responded that there were other people apart from the prescriber sharing same consultation room.

Table 9: Proportion of clients reporting to have been physically examined and privacy maintained during examination by health financing option

	User Fees		NHIF		Total	
	n	(%)	n	(%)	n	(%)
Physical examination done	79 /281	(28.1)	81 /282	(28.9)	160/282	(28.4)
Privacy during examination	56/79	(70.1)	81 /81	(100)	137/160	(85.6)

Among the clients interviewed, almost three quarters (74.4%) perceived the physical state of buildings at the health facilities they had attended as being satisfactory and 7.1% perceived this as being very satisfactory (see table 10). A lower proportion of NHIF clients compared to those who paid user fees perceived the physical state of buildings to be satisfactory (69.1% versus 79.7% respectively). Results in table 10 also show that a higher proportion of NHIF clients (22.3%) perceived the physical state of building in the health facilities that they attended to be not satisfactory compared to clients paying user fees (14.6%). The differences observed were statistically significant ($p<0.05$).

Table 10: Clients' perception on the state of buildings by health financing option used

Physical state of buildings	User Fees (n =281)		NHIF (n=282)		Total (n =563)	
	n	(%)	n	(%)	n	(%)
Very satisfactory	16	(5.7)	24	(8.5)	40	(7.1)
Satisfactory	224	(79.7)	195	(69.2)	419	(74.4)
Not satisfactory	41	(14.6)	63	(22.3)	104	(18.5)

P=0.016 Chi-square=8.26 Degrees of freedom=2

Table 11 shows that overall, 41.9% of the clients interviewed perceived the total waiting time they had spent to get health care services to be long, while 40.7% of them perceived it as being reasonable. However 17.4% of the clients interviewed perceived the total waiting time that they had spend to get health care services as being short. A similar proportion of clients using user fees and NHIF clients reported having had spent a long time to get care that is 41.6% versus 42.2% respectively. However a higher proportion of clients paying user fees reported the total waiting time to get care as being short compared to NHIF clients that is 21.4% versus 13.4% respectively ($P<0.05$).

Table 11: Perception on total time spent to get health care services health financing option used.

Clients' perception	User Fees (n=281)		NHIF (n=282)		Total (n=563)	
	n	(%)	n	(%)	n	(%)
Short	60	(21.4)	38	(13.5)	98	(17.4)
Reasonable	104	(37.0)	125	(44.3)	229	(40.7)
Long	117	(41.6)	119	(42.2)	236	(41.9)
P=0.032	Chi-square=6.88		Degrees of freedom=2			

When clients were asked to give their perception on the waiting time they had spent to get care from different hospital departments, analysis by health financing option used shows that 54.9% of NHIF clients perceived to have had spent long time before investigation was done as compared to 47.9% of clients paying user fees. While 88.1% and 85.4% of clients using user fees and NHIF clients respectively, responded that they had spent short time to wait before getting their medicines at the pharmacy and none of the clients interviewed reported to have spent long time to get service at the pharmacy.

Table 12: Clients' opinions on time spent in different departments in the Dar es Salaam Municipal hospitals

Time spent	Reception (n=281)				Consultation room (n=282)				Investigation (n=146)				Pharmacy (n =556)			
	User Fees		NHIF		User Fees		NHIF		User Fees		NHIF		User Fees		NHIF	
	N	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Short	137	(48.7)	144	(50.1)	101	(35.9)	116	(41.9)	34	(23.3)	38	(24.8)	243	(88.0)	239	(85.4)
Reasonable	69	(24.6)	70	(24.8)	81	(28.8)	73	(26.4)	42	(28.8)	31	(20.3)	33	(12.0)	41	(14.6)
Long	75	(26.7)	68	(24.1)	99	(35.3)	88	(31.7)	70	(47.9)	84	(54.9)	0	(0.0)	0	(0.0)

Table 13 shows a high proportion of clients (84.4%) reported that they were satisfied with the quality of health care services provided at the health facilities that they had attended. Among those who were satisfied 24.2% perceived quality of health care services to be very satisfactory, with a higher proportion of NHIF clients compared to client paying user fees reporting this, that is 27.3% versus 21% respectively. However, the findings are not statistically significant ($p>0.05$).

Table 13: Clients' satisfaction with quality of health care services by health financing option used

Satisfaction status	User Fees (n=281)		NHIF (n=282)		Total (n =563)	
	n	(%)	n	(%)	n	(%)
Very satisfactory	59	(21.0)	77	(27.3)	136	(24.2)
Satisfactory	180	(64.1)	159	(56.4)	339	(60.2)
Not satisfactory	42	(14.9)	46	(6.3)	88	(15.6)

P=0.144 Chi square=3.86 Degrees of freedom=2

Clients who reported that the quality of services that they had received as being satisfactory or highly satisfactory were asked to give reasons for stating so. Table 14 shows that the top three reasons that were mentioned include good attitude of health workers (89.9%), good skilled health workers (81.7%) and clean hospital surroundings (74.5%).

Table 14: Reasons for clients' satisfaction with quality of health care services provided in DSM Municipal hospitals by health financing option used

Reasons	User Fees		NHIF		Total	
	n	%	n	%	n	%
Good attitude of health workers	218	90.8	209	88.9	427	89.9
Health workers have good technical skills	192	80.3	196	83.1	388	81.7
Clean hospital surrounding	187	78.2	167	70.8	354	74.5
All prescribed drugs were available	135	56.5	149	63.1	284	59.8
Short waiting time	114	47.5	101	43.0	215	45.3

NB. Multiple responses

A total of 88 clients who were not satisfied with the quality of health care services that they had received were asked to give reasons for their dissatisfaction (See table15). The most frequently mentioned reasons for being dissatisfied with the quality of health services in the Municipal hospitals were long waiting time (72.7%), followed by failure to get prescribed medications (64.8%) and bad attitude of health workers (46.6%). A higher proportion of NHIF clients compared to clients paying user fees reported the reasons for dissatisfaction as being long waiting time and failure to get the prescribed drugs (i.e74.5% versus 70.2% and 70.2% versus 58.5% respectively). On the other hand many clients paying user fees compared to NHIF clients reported reasons for dissatisfaction as being bad attitudes of health workers and lack of enough privacy (i.e. 53.7% versus 40.4% and 47.6% versus 2.2% respectively).

Table 15: Reasons for clients' dissatisfaction with quality of health care services by health financing option used

Reasons	**User Fees (n=42)**		**NHIF (n=46)**		**Total (n=88)**	
	n	**(%)**	**n**	**(%)**	**n**	**(%)**
Long waiting time	29	(70.2)	35	(74.5)	64	(72.7)
I did not get the Prescribed drugs	24	(58.5)	33	(70.2)	57	(64.8)
Bad attitude of health workers	22	(53.7)	12	(25.5)	41	(46.6)
Health workers have Poor technical skills	9	(22.0)	19	(40.4)	21	(23.9)
Hospital surrounding not clean	14	(34.1)	5	(10.6)	19	(21.6)
Lack of enough privacy	20	(47.6)	1	(2.2)	21	(23.9)

Clients interviewed were asked to give their recommendations on what should be done in order to improve the quality of health care services provided at Dar es salaam Municipal hospitals (See Table 16), improved drug availability was the most frequently mentioned measure (73.0%), followed by reducing client waiting time (58.3%).

Table 16: Clients' recommendations for improvement of quality health care services by health financing option used

Recommendations	User Fee (n=281)		NHIF (n=282)		Total (n=563)	
	n	(%)	n	(%)	n	(%)
Drug availability be improved	207	(73.7)	204	(72.3)	411	(73.0)
Waiting time should be short	167	(59.4)	161	(57.1)	328	(58.3)
Physical state of buildings should be improved	49	(17.4)	62	(22.0)	111	(19.7)
Health workers attitude towards Clients should be improved	44	(15.7)	47	(16.2)	91	(16.2)
Cleanliness of the facility surroundings be improved	30	(10.7)	27	(9.6)	57	(10.1)

NB: Multiple responses

FACILITY CHECKLIST

Services Offered

The results of facility assessment showed that the three Municipal hospitals offer a good range of health care services. Only few services were not offered in all three hospitals surveyed, these were, sterile preparation services and an isolation wards, Temeke hospial was the only one that did not offer physiotherapy services (See table 17)

Table 17: Different services offered in the three Dar es Salaam Municipal hospitals

Service	Municipal hospitals		
	Amana	**Temeke**	**Mwananyamala**
Operating theatre	Available	Available	Available
Laboratory	Available	Available	Available
Radiology	Available	Available	Available
Blood bank	Available	Available	Available
Physiotherapy services	Available	Not Available	Available
Dental unit	Available	Available	Available
Eye unit	Available	Available	Available
Sterile preparation unit	Not available	Not Available	Not available
Refrigerated mortuary	Available	Available	Available
Isolation ward	Not available	Not Available	Not available

The laboratory records of Amana and Temeke hospital show that 11 out of 12 (92.3%) laboratory test listed were always performed (See Table 18) while Mwananyamala hospital was not doing culture and sensitivity and Widal test (See table 18).

Table 18: Laboratory tests always performed in Dar es Salaam Municipal hospitals

Name of the test performed	Muncipal hospitals		
	Amana	Temeke	Mwananyamala
Culture and sensitivity	Yes	No	No
Sputum for TB	Yes	Yes	Yes
HIV screening	Yes	Yes	Yes
Pregnancy test	Yes	Yes	Yes
Blood glucose	Yes	Yes	Yes
Liver function tests	No	Yes	Yes
Blood grouping	Yes	Yes	Yes
Blood examination for malaria parasite	Yes	Yes	Yes
Stool examination	Yes	Yes	Yes
Detection of urine bilirubin	Yes	Yes	Yes
V.D.R.L test	Yes	Yes	Yes
Widal test	Yes	Yes	No

Physical structure

The buildings of Amana, Temeke and Mwananyamala hospitals were in good physical state, the walls, ceiling doors and windows were intact, and walls were well painted. It was also observed that the clients' examination rooms were not adequate in all the three facilities. This caused more than one prescriber to share examination rooms in all three hospitals, except for special examination rooms serving NHIF clients which were always used by only one prescriber. The rooms had enough space and are well ventilated.

It was also observed that during physical examination visual privacy was maintained due to presence of patient screens, however audio privacy was difficult to maintain due to sharing of rooms by more than one prescriber. In all the three hospitals visited there were public toilets in the Outpatient department but they were not clean and were in bad physical state that needed immediate repairs.

Environmental cleanliness

Overall cleanliness of the surroundings was good in all the three hospitals visited. There was no long grass or paper debris scattered around the hospital surroundings. The rooms in the two health facilities were well kept, free from dust and spider web. All the three facilities visited had adequate solid and hazardous waste materials collection and disposal facilities, the drainage systems were functioning. All the three hospital had piped water and water storage tanks for ensuring constant flow of water. All facilities had adequate washing points near all service delivery.

Staff number and cadre

All the three facilities had adequate number of staff, but some cadres had more staff than the number specified in the standard staffing level specified by MOH. Cadres, which do not appear in the Ministry of Health staffing guidelines, were also noted in the staff inventories of the Dar es Salaam Municipal hospitals. These include Pharmacist, Supplies Officers, and Specialists

Table 19: Staffing levels of Dar es Salaam Municipal hospitals by June 2005

	Cadre	MOH Standard	Available Number		
			Amana	Temeke	Mwananyamala
1.	Medical officer in charge	1	1	1	1
2.	Hospital secretary	1	1	1	1
3.	Nursing officer in charge	1	1	1	1
4.	Dhobi	4	-	-	-
5.	Registry assistant	1	-	2	-
6.	Supplies assistant	1	1	1	2
7.	Mortuary attendants	2	2	2	1
8.	Assistant Dental Officer	1	1	1	1
9.	Dental Technician	1	2	-	-
10.	Dental therapist	1	-	1	2
11.	Medical attendant (Dental)	1	1	1	1
12.	Medical officer	2	5	8	3
13.	AMO (General)	9	28	23	19
14.	Clinical officers	13	22	12	46
15.	Nursing	10	38	46	44
16.	Public Health Nurse A	1	9	1	2
17.	Public Nurse B	5	4	2	2
18	Nurse midwives	33	51	58	78
19	Medical Attendant (Nurse)	25	53	44	45
20.	Pharmaceutical Technician	1	2	2	1
21.	Pharmaceutical Assistants	1	2	1	-
22.	Medical Attendant (Pharmacy)	1	6	1	1
23.	Laboratory Assistant	1	2	3	3
24.	Medical Attendant (Laboratory)	2	2	3	2
25.	Radiographer	1	3	1	2
26.	Radiographic assistant	1	2	2	1
27.	Medical Attendant (Radiography)	1	2	2	1
	TOTAL	**122**	**229**	**221**	**260**

Drug /Supplies availability

A review of drug records in the three health facilities visited showed that most of the essential drugs were available throughout the period of six months prior to the study. Table 20 shows the availability of 49 essential drugs and that of 12 diagnostic reagents. Amana had the highest proportion of essential drugs being always available (75.5%) compared to the other two hospitals (i.e. 71.4% for Temeke and 65.3% for Mwananyamala). Hospital records also indicated that Amana hospital had the highest availability of diagnostic reagents compared to the other two hospitals (See table 20).

Table 20: Availability of essential drugs and diagnostic reagents in the three Municipal hospitals (December 2004 to May 2005)

Item	Amana		Temeke		Mwananyamala	
	n	(%)	n	(%)	n	(%)
Drugs						
Always available	37	(75.5)	35	(71.4)	32	(65.3)
Sometimes available	10	(20.4)	11	(22.5)	8	(16.3)
Never available	2	(4.1)	3	(6.1)	9	(18.4)
Diagnostic reagents						
Always available	11	(91.7)	7	(58.3)	8	(66.7)
Sometimes available	1	(8.3)	3	(25.0)	1	(8.3)
Never available	-	-	2	(16.7)	3	(25.0)

CHAPTER FOUR

4.0 DISCUSSION.

Provider- client interactions.

Provider -client interactions include not only the attitudes of health workers but also how the provider takes trouble to make a proper diagnosis and communicate information about the illness and management to the client. Interpersonal relationship is an important reason for clients' choice of the facility to get care. In a study done in Sri Lanka it was found that, poor interpersonal relationships between public health providers and clients, made clients to seek out treatment from private health providers, inspite of the trust that patient had with the public health care institutions and in the technical competence of public providers (Russell, 2005). This study shows that there is a high rate (86%) of overall clients' satisfaction with the attitude of health workers in the three Municipal hospitals. However, a slightly higher proportion of clients paying user fees compared to NHIF clients perceived attitude of health workers to be poor, (i.e.14.9% and 13.1%, respectively), although the difference is not statistically significant ($p>0.05$).

The findings of this study are almost similar to those expressed in a study done to assess the quality of primary health care services in Moshi Rural district, where 92.5% of clients interviewed perceived the health workers to have a friendly attitude (Adam, 2001). However, Van der Geest et al., (2000) established low satsfaction with quality of health services in Zambia. The findings of this study were also contrary to what was reported in the NHIF implementation report, where it was indicated that NHIF members/

beneficiaries were not satisfied with the attitude of health workers towards them (NHIF, 2003).

Adequate consultation time is important in order to allow the provider to come up with the correct diagnosis and appropriate management of the condition presented by a client. Generally, almost all clients interviewed (91%) perceived the consultation time they had spent with the prescriber as being adequate. However, the proportion of clients who perceived the consultation time spent with provider, as being adequate was significantly higher among NHIF clients compared to those paying user fees (i.e. is 93.6% versus 88.3% respectively). This study however, did not measure the actual consultation time that a client spent with a provider. Msamanga et al., (1996) in a study done in two regions of Tanzania (Mara and Kilimanjaro) established an even higher proportion (97.5%) of respondents who reported that the consultation time with health care provider as being adequate.

Information exchange is also important during client- provider interactions. It describes the flow of health information between the provider and the client. Adequacy in information given to the patient is very important for better compliance with the treatment and hence improvement of quality of health services (Baker, 1990). In this study information exchange was assessed in the following areas; whether clients were given explanation about their health problems, counseling advice and instructions on how to use the drugs prescribed for them.

Results show that three quarters (75.0%) of the clients interviewed reported to have been given adequate explanation about their health problems, while 68% reported they had received counseling advice on their health problem and 97.2% reported to have been given adequate instructions on how to use drugs prescribed to them. The study findings show that there are no significant difference between clients paying user fees and NHIF clents. However the study did not involve direct observation of the interaction between provider and the client, instead it was limited to clients' perception on what they experienced or felt during their interaction with health service providers. Almost similar findings were reported by Mallya (2004) who established that more than two thirds (69%) of the clients using user fees interviewed reported to have been given adequate information about their health problems.

Study findings also show that only 28.4% reported to have had a physical examination done. Similar findings were reported in a study done in Bangladesh, where only 29.0% of clients interviewed reported to having been physically examined (Aldana et al., 2001). The issue of privacy during the physical examination was also assessed as an important part of provider client interactions. The results show that while none of NHIF clients reported to have lacked privacy during physical examination, 29.9% of the clients paying user fees reported that there was lack of privacy. The possible explanation for the observed difference is that providers serving NHIF clients do not share consulting room while those who serve clients paying user fees share consulting rooms. These findings are different from that established by Boller et al., (2003), where it was reported that

privacy of examination rooms was observed in 81% of consultation made in public facilities in Dar es Salaam.

Drug availability

The availability of drugs at the point of contact with health care system is one of the most important components of the quality of primary health care services and therefore a primary determinant of utilization of the health care services (Msamanga et al., 1996). This study shows that, overall 71.6% of clients interviewed reported that, drugs were not always available at the Municipal hospitals that they had attended, while a small proportion (1.4%) said that drugs were never available. Analysis of perception on drug availability by health financing option used shows that a higher proportion of NHIF clients (73.8%) compared to clients paying user fees (69.4%) responded that drugs were sometimes available while the opposite was true for clients reporting that drugs were never available, i.e. is 2.1% for user fees and 0.7% for NHIF clients. The results were different from what was observed in a review of drug records which showed more two third of essential drugs being always available in the three Municipal hospitals (i.e. 75.5% for Amana, 71.4% for Temeke and 65.3% for Mwananyamala).

Studies done in other parts of the country have also established low drug availability to be a problem. In a study done in Bagamoyo district for example, 63.6% of patients interviewed reported that drugs were not available all the time (Mallya, 2004).

Another study done in Moshi rural district found that 92% of respondents in public health units reported that drugs were available only in some days of the month (Adam, 2001).

Poor drug management has been shown to be the main cause of drug shortage in the health care facilities (Bhujel, 1996). In a study done in Tanga it was found that, drug shortages in the hospitals were a result of leakage resulting from poor supervision, control and management of drugs (Maier and Urassa, 1996). However, this study did not study the cause of drug shortage in Dar as Salaam Municipal hospitals.

Waiting time

Waiting time is the amount of time a patient spends waiting before receiving health care services or procedure. The results from this study show that clients' perception on waiting time was significantly different among the clients using user fees and those paying using NHIF. It was noted that a higher proportion of clients paying user fees (21.4%) perceived waiting time to be short compared to NHIF clients (13.5%). When clients were asked to give their perception on the time they had spent at different departments waiting to get service, they indicated that they had spent longer time waiting to get investigation done than waiting for other services (i.e 47.9% for the clients paying user fees and 54.7% for NHIF members/ beneficiaries). When clients were asked to mention reasons for the delays, long queue was mentioned as the main reason for spending long time. This was also confirmed during the assessment of

adequacy of rooms for various services using checklist where it was observed that there was only one laboratory and one Radiology unit. These were being used by all clients, regardless of health financing option used, hence delays in receiving services was more likely to occur.

A probable explanation for the difference in perceptions on waiting time among the clients using different health financing options in this study is their occupational status. About half of the NHIF clients interviewed were employed, while most of the clients who paid user fees were not employed. Individual who are employed are likely to complain about long waiting time, as they might have to rush back to work. Gilson et al., (1994) in a study on community satisfaction with primary health care services in Morogoro region, established that people prefer a shorter waiting time so that they are able to continue with their other activities.

Long waiting time was also mentioned in the NHIF implementation report as one of the factor causing dissatisfaction of clients with the quality of health care services received under National Health Insurance Fund (NHIF, 2003). In a study done in Bagamoyo district it was shown that a lower proportion of outpatients paying user fees (34.2%) compared to those in this study reported to having spent a long time waiting for investigation to be done (Mallya, 2004)

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Physical state of buildings

Physical state of buildings was also assessed as one aspect of quality of care. About 80% of clients interviewed perceived that physical state of buildings in the Municipal hospitals that they had attended to be satisfactory. The high rate of satisfaction with physical state of buildings is likely to be due to the fact that the buildings of the three facilities have been rehabilitated recently and in addition renovation of some of the buildings was still on going, as observed during physical assessment of the physical state of facilities buildings using a facility checklist.

An earlier study done on the quality of primary outpatient services in Dar es Salaam revealed that the structural aspect of quality particularly physical state of buildings was low in 1992 and that it had improved over years mainly due to construction, rehabilitation and improved maintenance of health facilities (Kanji et al, 1995). However, the results of the current study differ from those established in a study done in Bagamoyo district, where only 27% of community members interviewed had expressed satisfaction with the physical state of facility buildings (Mallya, 2004).

Reasons for clients' satisfaction or dissatisfaction with the quality of health care services.

Clients' satisfaction is regarded as one of desired outcome of health care services, and is increasingly being used as measure of the quality of care (Donabedian, 1997). Results of this study show that overall 84.4% of the clients interviewed were satisfied with quality

of health care received, with almost similar proportions of clients paying user fees and those who were NHIF beneficiaries/members reporting this, (i.e. 85.5% and 83.7% respectively).

When clients were asked to give reasons for their satisfaction with quality of services that they had received, the majority mentioned good attitude of health workers (89.9%) and health workers have good technical skills (81.7%) as leading factors for their satisfaction. These were followed by structural factors such as cleanliness of hospital surroundings (74.5%) drug availability (59.8%) and short waiting time (45.3%). The finding of this study show that provider attitude towards clients is the most powerful determinant of client satisfaction with quality of health care service.

Although it's difficult for a patient to judge health workers technical skills due to information asymmetry that exist between clients and providers, a higher proportion of the interviewees reported greater satisfaction with health workers technical skills. A study done by Singh et al (1999) on patients' perception and satisfaction of health care professionals at primary health care facilities in Trinidad and Tobago, also established this, where 74.2% of the clients interviewed were satisfied with skills and competence of the doctors. The high rate of satisfaction shown in the current study might be due to the fact that patients tend to have trust in the public health facilities and in the technical competence of public providers as have been established elsewhere (Russell, 2005).

Similar results were reported in a study done by Cloutier and Bisanda (1998), on community perception of quality of care in Dar es Salaam, which revealed that people consider process attributes of quality interpersonal communication and technical performance as very important determinants of clients' satisfaction with quality of health care services. The findings of this study also conform to the findings established by Msamanga et al., (1996), which revealed that perceived providers' technical competence and provider-client interactions to be the main factors which determined clients' satisfaction with quality of health care services

In this study structural elements of quality were mostly mentioned as dissatisfying factors, particularly long waiting time (72.7%) and poor drug availability (64.8%), followed by bad attitude of health workers (46.6%), poor technical skills of health workers (21.6%) and lack of privacy (23.9%). The findings from the studies done in other developing countries also show that long waiting time is associated with the highest level of dissatisfaction with quality of health care. For example a study done to assess client satisfaction and quality of health care in rural Bangladesh found long waiting time to be one of the factors that led to clients dissatisfaction with quality of health care (Aldana et al, 2001).

High level of dissatisfaction caused by long waiting time was also reported in a study done by Andaleb (2001), which revealed that long waiting time was contributed by clients overcrowding, understaffed and lack of resources. However, in the current study

understaffing is less likely to be the cause of long waiting time for the clients to get care, because the assessment of the staffing levels in the three Municipal hospitals shows that there is adequate number of staffs as per Ministry of Health of Tanzania Staffing Guidelines.

When clients were asked to suggest the most important things that need to be done in order to improve quality of health care services 73% reported that drug availability should be improved, while 58. % of them wanted waiting time to be reduced.

CHAPTER FIVE

5.1 CONCLUSION

- Both clients paying user fees and NHIF clients were highly satisfied with perceived quality of health care services that they had received at the Dar es Salaam Municipal hospitals, particularly with the level of client-provider interactions based on the attitude of providers towards patients, consultation time and information sharing.

- The study has shown that both user fees and NHIF clients perceived shortage of drugs as a problem in all the Municipal hospitals in Dar es Salaam.

- Over 40% of both NHIF clients (42.2%) and clients who paid for services using user fees (41.6%) perceived overall waiting time to be long. The study also showed that clients had spent longer time at investigation departments compared to other departments. With a higher proportion of NHIF clients perceived to having spent long waiting time for investigations to be done compared to clients using user fees, i.e. 54.9% versus 47.9% respectively.

- The physical state of hospital buildings was perceived to be satisfactory by more than three quarters of all clients interviewed, with a higher proportion of clients paying user fees being satisfied compared to NHIF clients.

- The most common suggestion made by clients on how to improve quality of health care services in the three Municipal hospitals were to improve drug availability and reduction of waiting time.

5.2 RECOMMENDATIONS.

- The availability of essential drugs in the three health facilities assessed need to be improved.

- Important measure should be taken to improve promptness in the health care services delivery through identification of the factors, which cause long waiting time at Dar es Salaam Municipal hospitals.

- Clients' opinions on the quality of services and their suggestions on how to improve quality of health care services should be taken into consideration when planning strategies targeted to improve quality of health care.

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