TEHIP News

Issue No. 5

- Community Participation
- Health Information Package
- Malaria Strategic Planning

A Newsletter of the IDRC/MOH Tanzania Essential Health Interventions Project

Cover: With support from the Council Health Management Teams, communities in both Rufiji and Morogoro Rural districts have mobilized resources to rehabilitate health facilities in their villages. Their initiatives have been successful in both districts and with regular supply of essential drugs, communities are now assured of better and improved health services. Women and children are the main users of the facilities. Pregnant women and children under five years of age are the groups most vulnerable to malaria infection. Malaria is endemic in both districts and it contributes heavily to the burden of disease.

Dilapidated health facilities such as the one seen above are common in the rural areas. Through initiatives of the Council Health Management Teams in Rufiji and Morogoro Rural Districts many of the facilities have been rehabilitated. (See page 6).

TEHIP News is published by the Tanzania Essential Health Interventions Project (TEHIP), a joint initiative of Tanzania's Ministry of Health and Canada's International Development Research Centre (IDRC). Contents do not necessarily reflect the views of partners working together in the development and implementation of the project.

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Community Participation: The lifeblood of the Health Sector Reform

By Faustin Fissoo

Mr. Faustin Fissoo

It is often said that there is nothing more difficult to undertake than to initiate a new order of things. This may be true in a number of initiatives but, always, where there s a will there s a way . The onset of the Health Sector Reforms (HSR) seemed a daunting task especially at the district level, the arena in which an interplay of activities is expected to produce tangible results.

Rufiji is among the districts at the forefront of the implementation of the Health Sector Reforms and I believe our experiences can be gainfully utilized in other parts of the country . Not only has the district demonstrated an increasing ability to plan and implement health plans through evidence-based planning, but it has also incorporated community participation to enhance the entire process.

Undoubtedly, the lifeblood of the Health Sector Reform is community participation as has already been demonstrated in various ways in the implementation of the policy at the district level. Using their own resources, communities have actively involved themselves in initiating, planning and managing their development projects. Most conspicuous is the rehabilitation of health facilities and to date, 21 have been rehabilitated using community contributions with some assistance from the District Council and donors. The facilities are now fully owned by the communities and the enthusiasm with which they are looked after and the benefits derived from them, indicates that their efforts would be sustained.

The empowerment of the community to identify their health and health related problems, set their priorities and solve their problems using available resources has far reaching consequences in the districts development initiative. Development activities that previously seemed impossible without government or donor funding are now being implemented through making use of internally available resources. Moreover, the community participation spirit has extended to other sectors as well.

The achievements in the HSR in Rufiji reflect the strength of implementing HSR concurrently with Local Government Reform. Planning for all sectors now starts at the village level and powers vested in the District Council have made the decision-making process easier, faster and more flexible.The Reforms have placed us in a position whereby all stakeholders can follow-up, monitor and even question what is taking place in the district.

TEHIP s support to the district has paid dividends twofold: The findings of the research studies carried out in the district are available and have resulted in a range of tools and supporting strategies which greatly help the Council Health Management Team to both plan and implement prioritised health interventions. Secondly, TEHIP s direct financial support to the CHMT as a simulated District Basket Funding, has helped build the capacity of personnel to implement the annual district health plans. We recognize also, with much appreciation, the forward push that came in the form of development assistance tools. Most of the previously dilapidated facilities in the district now have new looks and are well stocked with essential drugs and a new radio communications network is now in place through adoption of the Integrated Management Cascade.

All in all, the brief period in which Rufiji District has implemented HSR clearly shows that there is more to be gained. We have tried the process and as usual the proof of the pudding is in the eating.

Faustin Fissoo is the Rufiji District Executive Director.

TEHIP links with Health Sector Reform issues in Tanzania in areas such as community participation, resource allocation and integration, essential health interventions, human resource mobilization and development, management of primary health care, local and government roles in health sector, household health system relationship, burden of disease analysis, sustainability, equity, etc.

Delegation recommends areas of cooperation

A delegation from the Health Systems Trust (HST) of South Africa visited Tanzania in March 2001 to study TEHIP s scope of work and discuss possible areas of cooperation. Not only did the delegation learn some lessons from TEHIP s activities, but it also made some recommendations for HST.

South Africa has made great strides in transforming the health system since the democratically elected government came to power in 1994. However, last year s visit to Tanzania by a delegation from HST underscored the fact that there is much to be gained by collaborating and exchanging information and experiences.

The visit to TEHIP was of mutual benefit for both HST and TEHIP as they have many similarities in their activities. While HST was set up in early 1994 to assist with the transformation of the health systems in South Africa, TEHIP was established to test innovations in planning, priority setting and resource allocation in the context of the ongoing Health Sector Reform.

The delegation found out that there are many useful lessons that South Africa could learn from the Tanzanian Health Sector Reforms even despite the fact that SouthAfrica had introduced the concept of District Health System (DHS) and initiated the process of linking health districts to local government almost two decades ago. The delegation took stock of their experiences from the visit on activities such as: developing the capacity of Council Health Management Teams (CHMTs) to do evidence-based planning; strengthening the district health system, management; implementing the Integrated Management of Childhood Illnesses (IMCI) intervention; incorporating demographic surveillance of mortality and morbidity; and fostering linkage between research and development.

There are some useful approaches that the HST can adopt from TEHIP. The delegation made a number of recommendations that will enhance collaboration. It was suggested, for example, that the HST explores the possibility of collaborating withTEHIP around the Burden of Disease Profile and District Health Accounts Tool to assist CHMTs and councillors in South Africa to do evidence-based planning.

There is no doubt that TEHIP is doing excellent work in Morogoro Rural and Rufiji districts, contributing to improving the health status and quality of life of theTanzanians, concluded the delegation s report. With a project such as TEHIP, which produces leading innovations in health systems planning and development, Tanzania is a much richer country . However, they observed an all-embracing challenge for TEHIP to expand from being a project into creating a sustainable institutionalized system.

Health specialists from various fields met at Duluti in Arusha from December 4 - 5, 2001 to explore better ways of linking evidence to Health Policy.

Population and Health in Developing Countries: Volume1

Population, Health, and Survival at INDEPTH Sites

INDEPTH Network

IDRC 2002, ISBN 0-88936-948-8, US $25, Developing Countries US$15 356 pp.

This first volume of Population and Health in Developing Countries presents new and critical data recorded at the INDEPTH research sites. The impact of the HIV/AIDS pandemic in sub-Saharan Africa is leading to demographic changes in mortality patterns hitherto unseen and undocumented. This publication addresses this fundamental gap and, in doing so, describes patterns of mortality that current models are unable to provide. Starting with a description of the basic methods used, this volume summarizes mortality data, compares mortality patterns at INDEPTH sites, and reports on mortality patterns for Africa. Each INDEPTH site, including TEHIP's Rufiji and Morogoro collaborating DSS sites, has contributed a chapter in which it describes itself and the data it is contributing.

Future volumes in the series will present life tables for Africa and Asia as well as data on fertility trends, migration patterns, reproductive health, causes of mortality, and health equity.

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Villagers who sing their own songs, dance to their own tunes

In Rufiji and Morogoro villages, community members have had a passive view of their own development. Many believed that the government was solely responsible for their social and economic well being even in circumstances where they could help themselves. That laid back approach did not contribute to community development. In fact, it led to existing public facilities falling into a state of disrepairAfter many years of neglect, most of the health facilities, schools and other public buildings stood like ruins amid sprawling villages, a situation that adversely affected service delivery.

One of TEHIP s initiatives in development is to help communities shatter the myth that rehabilitation of facilities is the responsibility of the government. By promoting ownership of health facilities by local communities, TEHIP has used facility rehabilitation as an entry point to engage the community voice in the whole process of planning and implementation in the district.

Efforts to establish a sustainable mechanism for operation and maintenance are being put in place and benefits are already being realized. At Utunge village in Rufiji District, for example, a Tsh.200 contribution by a 78-year-old woman started the process of renovating a dilapidated dispensary and also ended a debate on whether rehabilitation of the dispensary was really a priority problem in the village.

Decisions made by villagers sometimes originate from group discussions.

Earlier, in the village assembly there was a tug of war between those who thought dispensary rehabilitation was a priority and others who favoured construction of new classrooms. How do you educate a sick family? asked the elderly woman amid ululations from women who mostly felt that the lack of a sound health facility in the village was a more pressing problem. The ululations reflected the mood and enthusiasm of the meeting. They also reflected the consensus of the people.Thereafter, a 14-member team was formed to lay the ground for the implementation of the decision. Strategies and a plan of action were then worked out.

After the decision had been made, the Council of Health ManagementTeam (CHMT) stepped in to provide assistance, and so did the Rufiji District Council. What previously seemed an impossible and daunting task suddenly became the darling of all villagers. Implementation of the project started in March, 2001 and it took barely six months to completion. The CHMT supplied building materials while villagers voluntarily provided the required labour.

Utunge dispensary is now a shining example of popular participation. Rather than wait passively for plans made elsewhere to be handed down to them for implementation, they have as a matter of fact, started singing their own songs and dancing to their own tunes. The dispensary has also undergone improvement in service delivery to more than 6,000 people from Utunge, Ikwiriri and Nyanda villages who use the facility. Now they can start to think about new classrooms using the same approach.

Elsewhere in Morogoro Rural District, health workers of the dispensary in Kiroka village had threatened to abandon the only health facility in the locality. After many years of disregard, the structure, made of cement blocks and roofed with corrugated iron sheets, had disintegrated and gathered moss. It was no longer fit for public use. Even when there was a supply of medicine, it was difficult to find a place to store it as the whole structure was leaking.

A litany of complaints by the villagers about the facility did not help change the situation. Nor did it attract assistance from donors or the CHMT . But a crucial meeting attended by users of the dispensary from Mfumbwe, Bamba, Kungwe, Kiziwa and Kiroka villages changed the attitude of the villagers and ushered them in a new direction. After an exchange of ideas they realized that after all, this was their facility. There s no point in complaining, we have the means to solve the problem , said Mzee Shaaban Mwinyimvua, one of the opinion leaders in the village.

Indeed they had the means, it was only the resolve that was lacking. By August 2000, building materials had been mobilized and villagers were ready to provide their labour . A few months later the Kiroka Dispensary clinical officer in-charge was no longer the withdrawn figure who had contemplated abandoning the facility. He was now discharging his services to the area from a tidy facility with an adequate supply of most essential drugs. The rehabilitated facility and sustained supplies rekindled his spirit to serve the approximately 7,800 people, who depend on the dispensary for health services.

Utunge dispensary in Rufiji District after rehabilitaion.

The writing is clearly on the wall in other locations. We have to help our selves first , said Athumani Mohamed Mambi, a member of the task force spearheading the renovation of Muyuyu Dispensary in Rufiji District which caters for more than 4,500. Although it took longer to convince people to participate in the rehabilitation of facilities, than it took them to do the actual work, the lessons learnt by the villagers themselves are essential. They are now applying the self-reliance spirit to projects in other sectors. Once you involve the community in planning and decision making, they are bound to achieve much, concluded Mgamba Hamad, the Kiroka ward executive officer. Give them a chance .

Reaching out to communities in remote areas

Morogoro Rural and Rufiji Districts, TEHIP s focal areas in the research and development activities, have unique communications and logistical problems. The low lying areas of Rufiji District are rendered impassable by the overflowing Rufiji River during the rainy season, while in Morogoro, the mountainous terrain hardly allows movement from the districtheadquarters to facilities in outlying areas.

Effective planning and delivery of essential health interventions are impossible if communications and logistical issues are not addressed in areas where even the orthodox telephone technology is not yet in place.

Despite the implementation of Health Sector Reform (HSR) and the creation of Council Health Management Teams (CHMTs), communication and involvement of Front Line Health Workers (FLHWs) in HSR have been limited.

An assessment of transport and supervision activities in the two districts in 1996 pinpointed transport problems as an obstacle to effective regular integrated supervision by the CHMTs.

After making headway in the planning process and providing clinical and public health interventions, it became necessary to put in place an integrated management system that would ensure integrated supervision and yield better results.

A strategy dubbed the District Integrated Management Cascade has been designed to address further autonomy , decision-making, advocacy and involvement within the district health facilities and promote orientation of all FLHWs towards the activities of the district health plan and HSR implementation.

The objective is to improve quality of health services in the district by permitting a functional hierarchy under the CHMTs to facilitate distribution, supportive and continuous supervision, training, referral and monitoring of health services taking place in their catchment areas. This will also promote improved communications and feedback between health facility personnel and CHMTs.

Against that background the CHMTs of Morogoro and Rufiji Districts adopted a system that delegates supervision and distribution activities to the health centres. Through this system, dispensaries within the catchment area are assigned to a co-ordinating health centre. Each health centre is now equipped with a radio call facility to improve communication and promote involvement in all matters concerning health delivery.

Both CHMTs are also equipped with radio in their respective of fices and mobile radios for their motor vehicles. To facilitate movement between health facilities, each of the co-ordinating health centres was supplied with a motorcycle and dispensaries were provided

with bicycles.

It was anticipated that once communications with health centres was in place, CHMTs would be able to promote a number of delegated activities. This type of communication can facilitate the training, follow-up after training and supervision activities, distribution and collection of drugs. Other uses could include patient management such as referral cases and supervision at facility level as well as personnel information such as staf f transfers and notification of when salaries are available.

The creation of a facility cascade will undoubtedly create other uses/issues and CHMTs will promote this activity in order to explore and define its full potential.

Morogoro District has 11 cascade catchment areas and Rufiji District has eight including the district headquarters. Cascade areas for Morogoro District are Ngerengere, Tawa, Duthumi, Mgeta, Kibati, Turiani, Mvomero, Mkuyuni, Melela and Mvuha. Those in Rufiji District are Bungu, Kibiti, Ikwiriri, Mbwera, Muhoro, Nyaminywili, Nyamisati and Utete.

The concept of an integrated management cascade was introduced in November 1998. and the installation of radios, purchase of motorcycles and bicycles took place in the last quarter of 1999. Implementation of the cascade system thus started in 2000.

The cascade was made operational by the provision of radios and motorbikes. This was achieved in most cascade centres by December 1999. Additional procurement of communication equipment was delayed pending a review of the optimal radio network systems. This has now been addressed and made more cost effective by incorporating both HF and VHF radio elements.

Bicycles provide a useful form of transport between rural facilities.

It was envisaged that all cascade centres would be fully operational by December 2001 and in addition, communications would also be extended to remote facilities or others with particular problems or demands.

Achievements already reported by districts include an increased number of supportive supervision visits/contactsto health facilities, the improved collectionof Health Management Information System (HMIS) data from health facilities and distribution of equipment and other supplies to health facilities.

TEHIP's simulated Basket Funding to Rufiji is also being used to improve communication and transport. Above: an EDP kit being delivered from a CHMT boat to a health facility in the Rufiji River Delta area.

Fewer patients: a welcome sign at Mchukwi

In the middle of Rufiji District, about eight kilometres from the main road to the southern regions of Lindi and Mtwara, stands a hospital that has for many years played a vital role in the provision of health services to thousands of people. Ironically, the facility is running short of patients but for healthy reasons. Mchukwi hospital which operates under the auspices of the Pentecostal Churches Association in Tanzania (PCAT) receives about 20,000 patients annually and is one of the two hospitals in the district which has a population of about 187,000.

Since 1996, the number of out patients seeking medical services from the 100-bed hospital has been declining as well as bed occupancy. About eight years ago bed occupancy was 74 percent but it has gradually dropped to 67 percent in 2000. However, the decline in the number of patients at the facility is not a worrying phenomenon. In most cases it is a sign of improved health. According to the District Health authorities, improvement of health facilities and delivery of health services have led to a decline in the number of patients seeking medical care.

Data from Morogoro and Rufiji areas have indicated that Malaria is the leading cause of health facility attendance, admission and in-patient mortality. When TEHIP introduced evidence-based planning to both districts in 1997 this triggered changes in the approach to the number one killer disease. More detailed analysis of the disease burden was undertaken by Council Health Management Teams which was then used to set priorities and influence budgeting and selection of cost effective interventions. Such efforts thus led to increased investment and delivery of effective interventions for Malaria cure and prevention.

The decline in the number of patients at Mchukwi hospital may be attributed to the results of the Integrated Management of Childhood Illnesses (IMCI) package and the widespread use of Insecticide Treated Nets (ITNs). These nets have been used in the project areas and are shown to be the most cost effective strategy in Malaria control. At Mchukwi the number of Malaria out-patients has declined from 1,064 in 1999 to 583 in 2000. The cost sharing system introduced in this NGO hospital in recent years could also contribute to the decline of patients in facilities, but the practice so far is that patients are not denied treatment in the event that they cannot afford to pay for the medical services. Medical services in government-run health facilities in the districts are still provided free of charge.

Steps taken to reach community goals

A health facility in the process of being re-built.

At a spectacular ceremony in Hanga Dispensary in Rufiji District a woman, the village chairperson, clad in colourful attire, walked up to the podium, shook hands with the guest of honour and walked back to her seat beaming and clutching a certificate. This is not an ordinary academic certificate. It is a testimonial to indicate that the rehabilitated health facility is now owned by the village.

Like many other villages that have benefitted from the development component of the Essential Health Interventions Project, Hanga has entered a new partnership and joint responsibility between the village and government for improving health services.

The certificate presented by Hon. Professor Masudi Mikidadi, the area's Member of Parliament, underscores the villagers commitment to undertake responsibilities to meet maintenance costs, maintenance needs and make the best use of the facility which they played a key role in refurbishing.

One of the development interventions of TEHIP is rehabilitation of health facilities. The CHMT put aside a modest amount of funds to compliment those of the district authorities and the local communities, to improve conditions in dilapidated dispensaries. From the outset it was proposed to emphasize the participation of local communities through setting out a complete work plan which included contributions of labour and materials by the local community to carry out essential rehabilitation and maintenance.

To develop and put in place a sustainable mechanism for rehabilitation and maintenance of health facilities, TEHIP contracted a group of experts in community based initiatives from the University of Dar es Salaam. This group conducted the training and supervised pilot approach in both districts. Such a move was necessary to ensure the promotion of ownership of health facilities by local communities and to build self-confidence in the rehabilitation and maintenance of local health facilities.

It also provided an opportunity to impart skills to district and local community leaders on labour based approaches to rehabilitation and maintenance.

Presenting TEHIP s experiences during a Regional Medical Officers (RMOs) Conference in November last year , Dr. Harun Kasale, the Project Coordinator said an essential rehabilitation initiative for community health facilities, with community participation was used as an entry point to engage the community voice in the whole process of district health planning, implementation,monitoring and evaluation.

The approach promoted ownership of health facilities by local communities and created community self-confidence and empowerment in the rehabilitation and maintenance of local health facilities.

Through these initiatives, appropriate skills are imparted to the local community and leaders on labour-based approaches to rehabilitation and maintenance. Another objective was to develop and put in place a sustainable mechanism for continuing rehabilitation and maintenance.

After the Tanzanian team, familiar with community labour-based approaches, was contracted to train and oversee the initial demonstration exercises, three dispensaries in each of the two districts were selected for demonstration. District based multi-sectoral teams were formed and were trained in the methodology . The approach was then introduced to the communities living near the selected dispensaries.

Communities were engaged in discussion and dialogue, which culminated in the production of rehabilitation work plans. In each plan, it was clearly set out what materials each community would supply, their labour contributions and what the District would provide them in the way of materials.

Milestones

- **1996:** A survey was carried out in both districts on the condition of all Health facilities.
- **1997:**The concept of community- based labour was introduced in both districts.
- **1998:** Pilot projects were carried out, to refurbish dispensaries as a means of capacity building.
  November: Refurbished dispensaries in Morogoro were handed over to local communities.
- **1999:**February, refurbished dispensaries in Rufiji were handed over to local communities.
- * **2000:** CHMTs use the process to refurbish more health facilities.

The rehabilitation exercise took about six to seven months to complete and community contributions ranged between 31% to 48% of the total rehabilitation costs.

Completion of the facility rehabilitation culminated in handing over ownership from District Authorities to the communities. Based on this demonstration, each district went on to rehabilitate several dispensaries using the same approach. So far 24 and 21 dispensaries in Morogoro and Rufiji respectively have been rehabilitated using the community-based labour approach and plans are underway to rehabilitate other dispensaries. Community ownership of these dispensaries has been realized and communities have formed rehabilitation and maintenance committees.

The multiplier effect is glaring. In Hembeti and Mlali, the villagers have gone further, on their own, to provide piped water and electricity to their rehabilitated dispensaries. In some areas, the communities decided to overhaul the original structure by expanding or by building new structures using the standard dispensary plans provided by the Ministry of Health. Villagers and district authorities are applying the methodology to other sectoral developments like wells and classrooms.

Meanwhile, a quantity surveyor from the Ministry of Health conducted a cost analysis survey of the rehabilitated facilities in Rufiji District and came up with interesting findings. The comparison between the actual monies spent to rehabilitate the facilities using community-based labour versus a private sub contract approach, showed that the community- based labour approach was cheaper. Savings varied between 40 to 60 %.

TEHIP has already learnt useful lessons from the approach. There should be transparency in the whole process, particularly in purchasing of materials, storage and utilization. This is of paramount importance in order to maintain the confidence of the community. Also effective co-ordination and communication between the District team and the village team is required in order to ac complish the task within an agreed period.

Villagers should take the driver's seat

Community members discussing health matters.

Against the backdrop of the Health Sector Reform, the Ministry of Health has embarked on an initiative to improve the health care of Tanzanians and create good health environments for all. As it strives to ensure delivery of essential health services to meet local needs, other collaborators including non governmental organizations are also working toward the same goal. World Vision is one such organization that is working with communities at the grass-root level to improve public health and clinical services. In an interview with **TEHIP News**, the Reverend Godwin Mwangoka, Coordinator of World Vision in Mlela Division, gives an account of how his organization is working hand in hand with the community in the rehabilitation of Mlela Health Centre in Morogoro Rural District.

Q: How did you get involved in the rehabilitation of Mlela Health Centre?

A: Well, we realized right from the outset that one cannot provide quality services in such dilapidated buildings. The buildings were in such a state of disrepair that it was just like putting up new ones. We mobilized our resources and started to put up structures in 1994. The work took about four years to complete.

Q: How were the people involved in this work?

A: The people had a problem with raising enough funds to carry out the rehabilitation. When they approached us for assistance, we told them that World Vision could give a hand only if they agreed and organized themselves to provide their labour. They agreed, but only after many meetings with the community. Some members of the community discouraged them from participating in self-reliance activities.

Q: Why were they being discouraged?

A: They were being told that the Government had a duty to do the work for them. Some elements in the community told villagers that so long as they paid the necessary taxes, it was up to the Central and Local Governments to do all development work.

Q: How difficult was it to have the community realize that they are responsible for their development?

A: In three years we had about 62 meetings and most of them were to educate the community that development will only be brought about by the people themselves. We told them that there is nothing much the Government could do. People should take the drivers seat in self reliance activities. Most of the people agreed to this and they came forward to do whatever work they were supposed to do. When construction work started, people turned out in large numbers to draw water and bring all the necessary construction materials to the site and they did all this with enthusiasm.

Q: What motivated them?

A: I think they all realized that they needed health services to be provided for them. They also wanted the services to be provided from a facility close to their homes. Women especially did not want to travel long distances for healthcare of their children. Actually, women were in the frontline in building this health centre.

Q: How else was World Vision involved in developing the facility?

A: We have been able to provide clinical and immunization facilities. We have also provided health education to service providers and Traditional Birth Attendants. World Vision has organized a number of workshops for government employees in the Ministry of Health.

Q: Have you also been involved elsewhere in the rehabilitation of health facilities?

A: We have been involved in the rehabilitation work of Lubungo, Mlali and Mkata dispensaries as well as Mangae, Mikongeni Pekomisegese and Magali dispensaries. We have also been involved in the rehabilitation of residential houses for health workers in Magali, Mlali and Mangai Dispensaries.

Q: What lessons have you learnt when working with communities?

A: What we have realized by experience is that once people are involved in decision making on matters which concern them, they are always willing to do whatever they think will bring about their development. Involve the people in planning, decision making and implementation and you will see the results. We have also learnt that people are discouraged if their leaders are unwilling to make firm decisions and commitments. Villages with good leadership have made tremendous progress.

Unpacking rewards of a health information package

Health planning information must come from health facilities, communities and households.

One factor that contributes to the death of millions of people in Africa from preventable causes may appear too simple to take into consideration: it is a lack of reliable information in addressing the real needs of the people.

In a robust health system, a reliable information base is needed to identify , prioritise and budget for required health interventions and monitor and evaluate the resulting impact .

The Ministry of Health recently developed an information strategy for strengthening the health system and health reforms. The efforts helped to highlight the fact that despiteTanzania s widespread network of rural clinics, up to 40% of the people with life-threatening illnesses were not receiving any formal health care in the period before death.

An elaborate health information package that accesses important data from the community to the national level, pinpoints areas where coordinated efforts need to be directed.

In Tanzania we have learned that this information must come from both health facilities and from communities themselves , said Dr . Hussein Ali Mwinyi, Deputy Minister of Health when addressing the Commonwealth Regional Health Community Ministers Meeting in Dar es Salaam in October 2001.Gathering information from both sources ensures a true picture of health system functioning and prevailing health conditions among the population.

Main Sources of Information are:

The first source: Routine health information systems, which are primarily based at health facilities provide the necessary data for local heath authorities to plan and manage health facilities. At national level this information contributes to monitoring health sector performance in the areas of inputs, outputs, and process.

The second source: National surveys and focused research projects, are being drawn upon more and more for policy making and planning. Some local council health management teams have created specific posts of District or Municipal Research Co-ordinator .

The third source: Tanzania is pioneering the implementation of sentinel demographic surveillance systems for a variety of health and poverty related issues. Sentinel systems generally aim at providing a picture of community-level health and risk factors

Primary techniques in collecting required information:

* Routine information systems, such as the 'Health Management Information Systems' and 'Integrated Diseases Surveillance',
* Surveys and research, such as the periodic "Demographic and Health Surveys" and
* Sentinel surveillance systems, in which intensive data collection at a few selected locations is used to extrapolate a general picture of population health and health risks.

over time. In addition, valuable information is gained on the impact and outcome of health system changes that cannot be reliably collected in any other way in most African countries which lack a vital Registration System.

Tanzania, according to the Deputy Minister of Health, has started to feel the impact of the information packages despite the fact that not all the components are in place.

At the district level, the importance of using an integrated package of data sources can be seen. When community-based information about the low rates of health facility use and the burden of malaria deaths became available, it motivated one of Tanzania s rural district councils to completely re-assess their health system priorities. Major resource commitments were made to improve curative services to children through the Integrated Management of Childhood Illness, and to promoting household-level malaria prevention through the use of insecticide treated nets.

At the national level, information from a variety of routine and sentinel information sources was used, for example, as the evidence base from which the Ministry of Health developed the National Essential Health Interventions Package, and provided a clear and concise evidence base for the country s recent change in anti malarial drug policy

The Deputy Minister said, "Tanzania is in the fortunate position of having more such sites than any other country in the world," although these demographic surveillance sites are present in many of the countries represented at the Commonwealth Regional Health Community Ministerial Meeting.

The Ministry s National Sentinel System will be able not only to contribute to the health sector s own information needs, but can serve as a platform for producing data on many of the indicators required for the multi-sectoral responses to malaria, the National response to the AIDS epidemic, and monitoring T anzania s Poverty Reduction Strategy.

Seeking information based on community and household level realities

The Rufiji DSS employs the household registration System (HRS) which is a unified, decentralized, field and data system documenting all births, deaths, causes of death, marriages, in and out-migrations and socio-economic status.

Rufiji Demographic Surveil lance System (Rufiji DSS) is the only continuous source of rural, population-based data in coastal Tanzania. The Rufijii DSS can provide an important source of information on the burden of disease, grounded in community and household level realities. This data is essential for planning and priority setting.

The Rufiji DSS was established in 1998 as one of the major components of the Ministry of Healths Tanzania Essential Health Interventions Project (TEHIP).

It commenced with financial and technical support from Canada s International Development Research Centre and from the UK Department for International Development (DFID) through the Adult Morbidity and Mortality Project (AMMP).

The aim of TEHIP's Rufiji DSS is to provide packaged burden of disease data to district health authorities and the Ministry of Health to inform planning, priority setting and evidence-based decision-making and to monitor the impact of health reforms.

Rufiji is one of the six districts of the Coast region ofTanzania with an estimated population of about 187,000. The surveillance areas were selected by purposive sampling and are situated on the northern side of the Rufiji River basin. This DSS area comprises 31 villages with a population of approximately 93,000 in 19,000 households.

The Rufiji DSS employs the Household Registration System (HRS) which is a unified, decentralized, field and data system documenting all births, deaths, causes of death, marriages, in and out-migrations and socio-economic status. This is done continuously , with each household visited every four months for updates.

Currently, Rufiji DSS employs 52 full time staff that include one station-manager-demographer, one administrator , one data manager, one field manager, one data assistant, one filing clerk, one secretary, three data entry clerks, 14 field supervisors, 25 enumerators, a driver, a watchman and a cleaner About 150 non-salaried, community-based key-informants also assist the system by dual reporting of deaths and births.

Ministry outlines 5-year plan to fight malaria

Despite efforts to control malaria since 1990 when the Ministry of Health put into effect the National Health Policy, the disease is still the major cause of death, illness and socio-economic problems in Tanzania. It is estimated that malaria cases per year range between 14 million to 18 million. To reverse the situation the Ministry of Health is implementing a five-year Malaria Medium Term Strategic Plan (MMTSP). The plan aims at reducing deaths and disease due to malaria in all parts of the country by 25% by 2007 and by 50 % by 2010. What are the strategic approaches and interventions to be implemented to achieve this goal?

The five-year Malaria Medium Term Strategic Plan covers the period between 2002 and 2007 and is in line with the Roll Back Malaria (RBM) initiative. Its goal is to reduce malaria to a level where it is not a major public health problem nor an obstacle to socio-economic development. To achieve the goal emphasis is placed on four strategies:-

1. Improved malaria case management

Effective management of malaria clinical cases is still the most viable and valuable intervention to reduce the burden of disease, especially mortality . In view of the fact that chloroquine treatment failure is now averaging 52%, a system to monitor the efficacy of anti-malarial drugs is in place.

Targets to be attained by 2007 at community and facility levels :

Access and ability to use correct affordable and appropriate treatment for febrile episodes in children under five years within 24 hours, should be raised from 19 % to 60%.

At least 80% of uncomplicated malaria cases and severe malaria cases in children under five years should be appropriately treated in the health facilities at all levels of health care.

2. Malaria Prevention

This strategy will mainly focus on increasing Insecticide Treated Nets (ITNs) demand and use at the household level including the re-treatment of nets. Results from ITN trials throughout Africa have shown that ITNs can reduce mortality in children under five years of age by 20% and the number of malaria episodes experienced by protected children by 50%. ITNs have been demonstrated to be one of the most promising and cost effective methods available for controlling malaria in sub-Saharan Africa. In Tanzania a national strategy to promote effective use of ITNs has been developed.

Targets for children under five years and pregnant women:

By 2007 at least 60% of the children under five years of age and pregnant women should be sleeping under an appropriately treated mosquito net.

3. Malaria prevention in pregnancy

Pregnant women and children under five years of age are the groups most vulnerable to malaria infection. Research has shown that pregnant women living in malaria endemic areas, (i.e. 93.7% in Tanzania) who receive intermittent treatment doses of SP during their pregnancy, enjoy better health and have bigger healthier babies than women from the same areas who have not had intermittent treatment. In Tanzania, although communities and health providers are aware of the availability of malaria preventive measures in pregnancy, there is still low uptake of malaria prophylaxis and use of ITNs.

In Tanzania a national strategy to promote effective use of ITNs has been developed.

The target by 2007 is:

At least 60% of pregnant women should be effectively protected against malaria.

4. Malaria Epidemic Prevention and Control

Unstable malaria transmission areas such as fringe highland and semi-arid zones are prone to malaria epidemics which cause a large amount of debility and death. About 25% of the population in Tanzania live in malaria epidemic prone zones and where epidemics have occurred they have inflicted high morbidity and mortality as well as disruption of the socio-economic set up of the affected population. Experiences in the last 10 years show that malaria epidemics have caught authorities and communities unaware because there are no mechanisms and facilities to signal early warning of the epidemic.

The target by 2007 :

All epidemic prone districts should have the capacity to detect early and respond appropriately to malaria epidemics.

To implement the four strategies which have been detailed above, the Malaria Control Programme within the Department of Preventive Services will be strengthened to enable effective coordination and management of the Malaria Medium Term Strategic Plan.

Cholera threatens some reform gains

When the residents of Ikwiriri Division in Rufiji District were happily waiting to celebrate Idd el Fitr at the end of December last year , news of an outbreak of cholera started spreading like bush fire.

It all started with the death of a 14-year-old girl who suddenly started vomitting and complained of fitful diarrhoea. She died a few hours after reaching the nearest health facility. For a period of one month, from December 24, 223 people were reported to have contracted cholera in the Division which has a population of 21,508. Of those 223, seven died of the disease.

The problem is that you discharge 10 patients and then you admit 17 new cases soon after or even simultaneously, said the Division Health Officer, Laban Mwanati Kitule. The epidemic consumes a big chunk of resources, drugs and man-hours that could have been devoted to common health problems in the area. This in turn slows down any achievements obtained in the district through interventions that are aimed at improving health care delivery.

Laban Mwanati Kitule, Ikwiriri Division Health Officer.

The outbreak of the disease brought the area to a virtual standstill. Schools, restaurants, kiosks and liquor outlets were closed down. It sparked a health education campaign to persuade people to adhere to health regulations, boiling drinking water and using latrines. Cholera is one of the easiest disease to curb as long as people adhere to basic health regulations. The response from the people was good but there is a danger of the disease transforming from an epidemic to an endemic situation which means that efforts to fight common childhood illnesses in the area would now be devoted to cholera. Once people get used to this disease, they may end up saying this is always with us and no longer take precautions seriously , said Laban Mwanati Kitule, the Ikwiriri Division Health Officer.

HIV/AIDS

Basic facts

- 49.9 million were infected world wide In 2000.
- Every day 15,000 are infected.
- 37 million out of 49.9 cases are in developing countries.
- 44,250 were infected in 2001 in Tanzania
- Most of these are aged 20-49 years.
- Females are mostly infected between the age of 25-29 years.
- Males between the age of 30-34 years
- Until now, 1.75 million Tanzanians have been infected.
- Male to female ratio is 1: 1.3

Source: WAMATA, Dar es Salaam

Tanzania witnesses dramatic drop in Leprosy cases

Leprosy cases have dropped from over 35,000 in 1980 to about 5,235 in the year 2000. Since the National Leprosy Control Programme was launched in 1977 more than 100,000 cases have been cured.

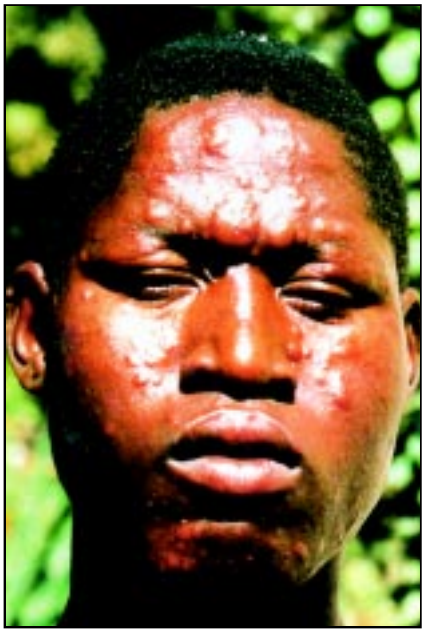
The Minister of Health, Ms Anna Abdallah revealed this in Hombolo in the outskirts of Dodoma municipality during the climax of celebrations to mark the World Leprosy Day at national level on January 27th this year. The theme this year is leprosy is curable, go for early investigations.

The Minister appealed to people suffering from the disease to report to hospitals and health centers as early as possible because the disease is curable.

Ms Abdallah has described this as a remarkable achievement, which must be sustained. The Minister urged donors to continue funding the Leprosy Control Programme. She made the appeal amid reports that some donors have already halted their support for the anti-leprosy drive.

It is estimated that Tanzania has about 30,000 victims of leprosy who have been disfigured. The Minister appealed to the public to extend moral support to their relatives. She regretted that leprosy has been associated with misfortunes in the family and that victims have been isolated from their families and forced to form their own settlements. Leprosy is just like any other disease and is curable. Those who suspect that they have contracted this disease should report to health facilities for medical attention, she said.

Regions which have particularly large numbers of leprosy cases include Morogoro, Mtwara, Kigoma, Dar es Salaam, Coast, Tanga and Dodoma.



Achievements in curing leprosy must be sustained.

Too many resources devoted to war amidst threat of diseases

As the threat of HIV/AIDS and other infectious dis eases looms larger, there is growing concern that nations are spending more on wars at the expense of disease control programmes that could save millions of lives in their countries.

Among the latest national leaders to express the concern isTanzanian President Benjamin William Mkapa who with regret remarked that the world was spending far more resources on wars or preparations for wars whilst ignoring infectious diseases such as HIV/AIDS, tuberculosis and malaria which kill many more people than war.

He made the remarks when opening the 34th Commonwealth Regional Health Ministers Conference in Dar es Salaam on October 22, 2001.

Quoting the World Disaster Report released in 2000 by the International Federation of the Red Cross and Crescent Societies, President Mkapa said that the death toll due to infectious diseases was 160 times more than the number of people killed in natural disasters in 1999.

He said global military spending alone reached Tshs 86.4bn/= in 1995 compared to the the Tshs 15bn/= spent annually on AIDS, tuberculosis and malaria prevention and control programmes worldwide.

Malaria kills more than one million people a year worldwide. Ninety per cent of them are in Africa. But malaria is not a high priority research area for the large pharmaceutical companies, probably because it afflicts poor people who cannot afford new and expensive drugs, President Mkapa said.

It is estimated that AIDS killed 2.3 million people in Africa in 2001 and 28.1 million Africans now live with the virus. Without adequate treatment and care, most of them will not survive the next decade.

Highlighting the relationship between poverty and health, President Mkapa explained that poverty, was at the heart of the shortcomings in the health delivery systems in developing countries.

The President said that poor health exacerbated poverty by reducing productivity through ill health and by increasing the cost of medical care, including care for easily preventable diseases.

Unsafe abortions, haemorrhages, infections, high blood pressure and obstructed labour that cause maternal deaths have their roots in developing countries poverty and poor access to quality medical care.

President Benjamin William Mkapa

According to the World Health Or ganization (WHO), 99% of 500,000 maternal deaths that occur every year in the world are in developing countries. He said international co-operation could help to reduce such unnecessary deaths.

On HIV/AIDS, President Mkapa said most people in Sub-Saharan Africa are being infected or infect others out of ignorance or because their governments cannot provide reliable and accessible facilities nor adequate counseling services.

Due to the shortcomings, 90 to 95 percent of Sub-Saharan African people carrying the virus do not even know that they are infected.

The President also underscored the importance of correct diagnosis of diseases in order to save lives of thousands of people who die through wrong diagnosis of diseases.

He urged for a stronger partnership between governments, aid or ganizations, international civil society and donor agencies to work together to improve the diagnosis of diseases that afflict, debilitate and kill people. Patents for medical knowledge and drugs should not stand in the way of saving lives by the thousands, he said.

Participants to the meeting held under the auspices of the Arusha-based Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa, included Tanzania, Swaziland, Kenya, Lesotho, Seychelles, Uganda, Mozambique, Malawi, Zambia, Mauritius and Zimbabwe. Various donor agencies and cooperating partners also attended the meeting.

Established in 1974, the Commonwealth Regional Health Community is a regional inter- government organization that fosters and encourages cooperation in health in East, Central and Southern Africa.

Rufiji DSS:
Bracing for new knowledge and information

Vision

Rufiji Demographic Surveillance System (DSS) vision is be a Tanzanian center of excellence and innovation generating new knowledge and infor - mation in support of policy , planning, research and capacity building for health, human and economic development in resource constrained settings.

Mission

The purpose of the Rufiji DSS is to provide services, monitoring and evaluation research, and capacity building:

- **Service:** To contribute to the development of the new Tanzania National Sentinel Surveillance (NSS) System by providing unique, essential, household level information individually tailored for policy, planning, and research needs;
- **Monitoring and Evaluation:** To provide a platform for high quality household survey data for operational field trials of health and socio-economic interventions in rural populations;
- **Capacity Building:** To provide a platform for training in applied field research and practical health, socio-economic and demographic survey methods.

Key Objectives

Objective 1: Service:

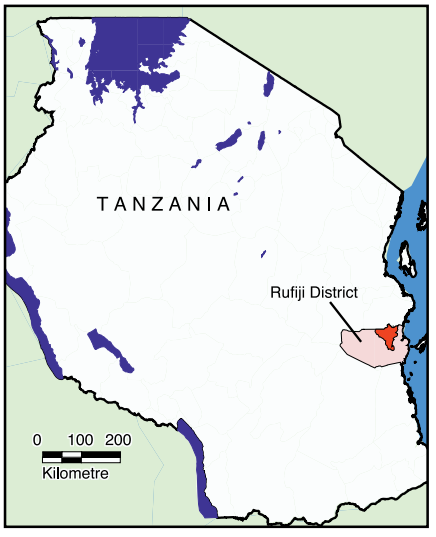
- To document all births, deaths, in-migrations, out-migrations, socio-economic status and causes of death in a large population characteristic of coastal East Africa.
- To provide and promote the use of annual burden of disease profiles and other DSS information in Ministry of Health and District level priority setting for health sector planning through the NSS.
- To ensure and strengthen the translation of appropriate information, evidence and research results into public health action.

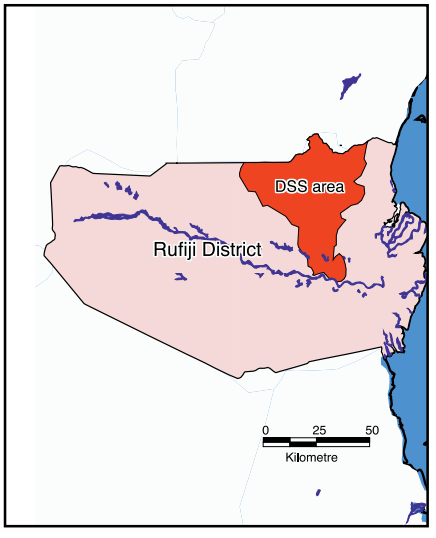
Objective 2: Monitoring and Evaluation:

- To provide a platform for longitudinal, trans-disciplinary research on household determinants and impacts of poverty, food insecurity, socio-economic inequalities, services access/utilization, poverty alleviation interventions, and health reform initiatives.

Objective 3: Capacity Building:

- To offer facilities for practical field training in applied health research, demography, socio-economic and population development issues.





Rufiji DSS Surveillance Area

TEHIP News

TEHIP News is a development oriented newsletter published by the Tanzania Essential Health Interventions Project (TEHIP). It is aimed at linking health development workers and researchers, especially those struggling with questions about how best to allocate human and financial resources to maximise the health status of populations in low income countries. TEHIP hopes that the newsletter will stimulate new ideas and enthusiasm. The newsletter is free of charge to institutions and individuals working to promote health and development. The newsletter is also available on the IDRC website:// http:www idrc.ca/tehip.To be included in our mailing list write to:

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Printed by Colour Print (T) Limited