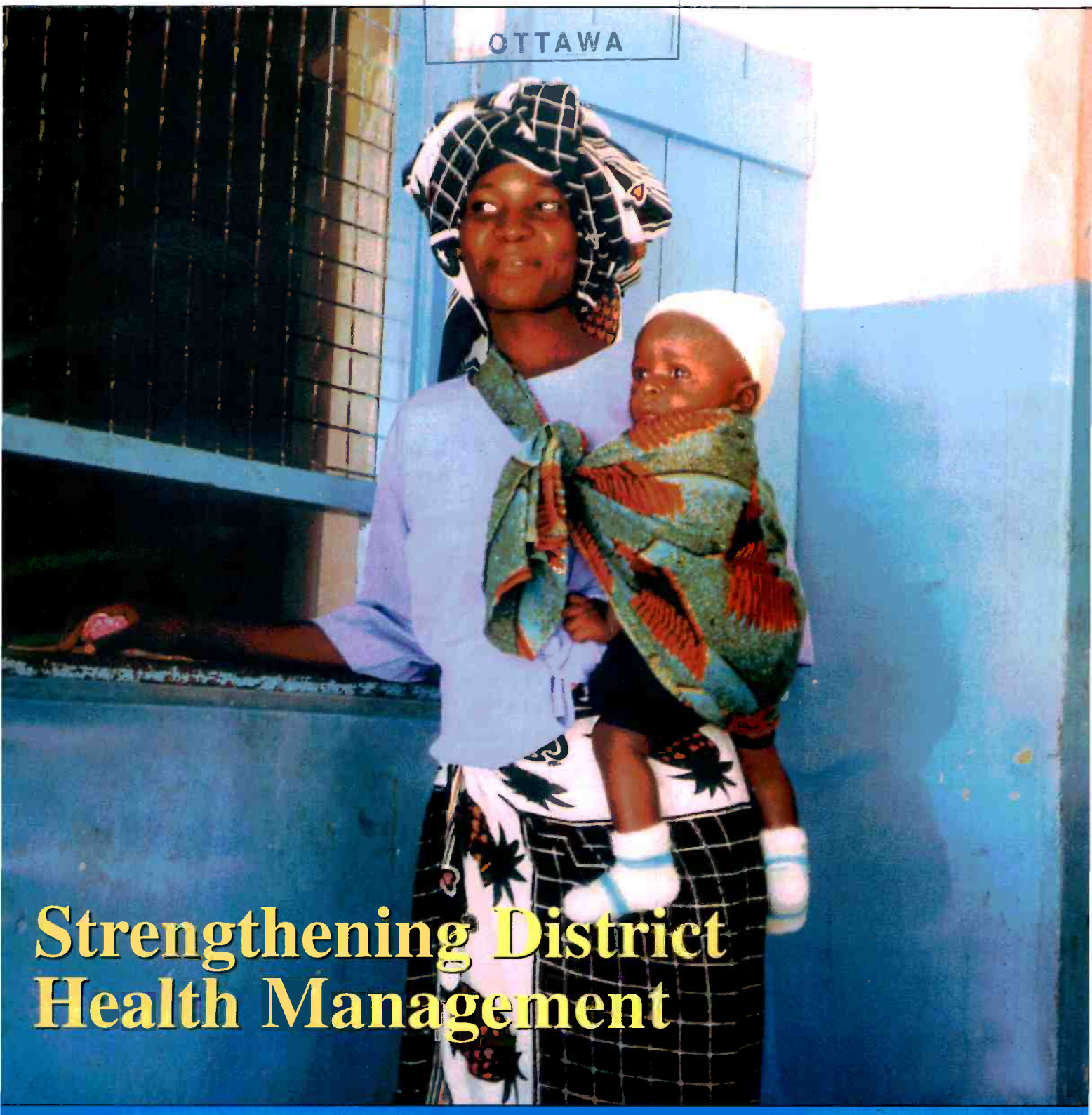
TEHIP News

Vol.1 No.2 July-December, 1999



Strengthening District Health Management

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

Cover photo

One of the goals of TEHIP is to increase district level capacity to effectively deliver the selected health interventions. Children and women are among the beneficiaries of the interventions.

TEHIP News is published by the Tanzania Essential Health Interventions Project, 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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The District Health Management Team functions include ensuring the delivery of high quality, cost effective district health services. More information on pages 6 & 7.

CONTENTS

EDITORIAL

A butterfly cannot fly with one wing

Often it is not easy to assess the impact of a project when it is only in its second year of implementation. However, as I was involved in the planning of TEHIP when I was the Director of Preventive Services in the Ministry of Health I have closely followed-up the path trodden to bring it on board and also I had the opportunity to monitor its implementation.

Dr. Peter Kilima

Unlike vertical projects focussed on districts, TEHIP is basically a local government programme. Its activities are performed with a high degree of transparency and are embedded in the local government system. Right from its conception and initial planning, it involved all stakeholders as well as the clientele population, a factor which has enabled communities, through the District Health Management Teams (DHMTS), to participate in the management of their own health eventually leading to working out of more appropriate health plans that reflect local health needs and problems.

Although TEHIP is still battling with teething problems its contributions to the Health Sector Reform are definitive. The two districts that are implementing the project have come up with more rational plans based on relatively reliable health information. It has shown the strength of basing plans on evidence and directly involving the beneficiaries.

As a butterfly cannot fly with one wing, likewise development cannot be achieved without research. The benefits of marrying the two in provision of health care have been demonstrated by the project. Progress is evident in the implementation of the test package on the Integrated Management of Childhood Illnesses (IMCI). Gathered evidence has shed light on how best we could fight the major killers of children - malaria, diarrhoea, pneumonia and malnutrition - through prevention and treatment. Also the various tools developed in the course of implementing the project, such as those for cost tracking, community voice,district health budget planning, burden of disease analysis and cost effectiveness analysis, will go a long way in solving problems encountered in the day-to-day administration of health services and rationalize referral procedures.

Undoubtedly, the strength of the project is its thrust in capacity building which includes training and technical, financial and material assistance. Although the major challenge of any organization is the retention of the capacity built overtime, the training of DHMTs and other district workers has marshaled the capacity and means to plan, set priorities and allocate resources. This is an invaluable asset that will continue to be utilized even when TEHIP support to the district comes to an end.

Dr. Peter Kilima
Former Director of Preventive Services, Ministry of Health

Frequently asked questions about TEHIP

What is TEHIP?
The Tanzania Essential Health Interventions Project is a collaborative venture between Tanzania's Ministry of Health and Canada's International Development Research Centre. TEHIP was established to test innovations in planning, priority setting and resource allocation in the context of on-going health reform. Funding is provided by both the governments of Canada and Tanzania.

What does TEHIP do?
TEHIP examines the feasibility of institutionalizing a more evidence-based approach to planning in the specific context of decentralization at the District level in Morogoro Rural and Rufiji Districts.

What Questions does TEHIP Address?
How and to what extent can district health plans be more evidence based (e.g. evidence from burden of disease, cost-effectiveness, community voice and system capacity); how and to what extent can such plans be implemented; and how, to what extent, and at what cost do such planning interventions have an impact on population health?

How was TEHIP conceived?
Over a period of three years following publication of the WDR 1993 Report "Investing in Health", a series of broad consultative design conferences were held at international and national levels involving health development and research practitioners from a wide variety of multi-lateral, bilateral, government and academic institutions (World Bank, WHO, IDRC, CIDA, UNICEF, Edna McConnell Clark Foundation and the Government of Tanzania) to agree on the hypotheses to be tested and the approach to be taken.

What is the time frame of TEHIP?
Support to the project officially commenced in October 1996, while support to Districts and to the Tanzanian research community began in 1997. The project will unfold over 4 annual district health planning cycles ending in 2001.

INTERVIEW

Team-work reaps reward for the district

In implementing the Health Sector Reforms, districts have been given greater autonomy in planning services and allocating resources in response to local needs. At the helm of Health Reforms at the district level is the District Medical Officer (DMO) who heads the District Health Management Team (DHMT). In this issue, Morogoro Rural DMO, **Dr. Harun Machibya** relates his experiences in the implementation of the Tanzania Essential Health Interventions Project in his district.

Q: What is your role in the DHMT?
A: As the chairman of the District Health Management Team, I am the coordinator of activities in the health sector at the district level.

Q: Are there any changes in health care delivery since the TEHIP took off?
A: TEHIP has empowered the district to work out its plans and implement them with autonomy. Although some people think that we are implementing a donor project that is not the case. TEHIP came along at the time when decentralization was taking off the ground and the changes effected through the project gave us more resources and authority to decide on our development. Before TEHIP implementation we did not identify and prioritize our interventions

Dr. Harun Machibya, Morogoro Rural District Medical Officer

rather we implemented plans worked out centrally. Even in budgeting the tendency was to add some percentages to previous years' planned and budgeted activities. Now that we have the necessary resources at our disposal, we find that we have more work to do and this new situation has given us job satisfaction.

Q: How is the district contributing in capacity building?
A: We play a major role in training of health workers. We have provided technical support to our health workers on how to write quarterly reports. We have worked out a checklist on supervision as well as IMCI formats that are currently in use. We have also modified some training materials for example Ten Steps to a District Health Plan which is now more user friendly. The Workbook was written by the Iringa Primary Health Care Institute.

Q: What factors in TEHIP enhance the implementation of District Plans?
A: There are several, but I would rank availability of resources as number one. With the availability of vehicles and other modes of transport, mobility has been made relatively easier to enable the DHMT and other health workers perform their duties even in the very remote areas of the district. Through the project we have access to a working telephone as well as E-mail

continued from page 3

Why does TEHIP include Research with Development?

Following the WDR '93, there has been growing interest in basing health systems development on a foundation of evidence. How to do this is unknown, especially at the District level where health reforms are delegating more responsibility and authority. Therefore TEHIP is about testing a new process of planning and priority setting. Tanzania has recognized that the health reform process includes research. All TEHIP research is conducted by consortia of Tanzanian research institutions.

What is happening now?

Full time research is underway in the areas of:

- Health Systems: DHMT Planning and Implementation Processes
- Health Behaviour: Household Trends in Utilization of Essential Health Interventions
- Health impacts: Direct demographic surveillance of mortality
- Planning Tools: Development of practical tools for priority setting and planning
- Regular Development activities at the district level addressing: Direct funding support to district planned activities for essential health interventions training and delivery (IMCI, ITNs, EPI, STDs, TB - Dots).
- Financial and administrative support and capacity building (e.g.) provision of training in computers, DHMT office refurbishment, funding support to transport and communications, strengthening budgeting and accounting of the district health plan, implementation of a cost tracking system at facility level.
- Capacity building to address areas of weakness e.g. team building, delegation, management, communication, planning, reporting.
- Community involvement initially targeting community-driven health facility rehabilitation and maintenance.

What is TEHIP's role in defining the Essential Health Interventions Package?

- TEHIP does not prescribe the package, but proposes and tests principles by which District Planners can improve technical and allocative efficiency and select the best mix and coverage of cost-effective interventions in response to their priority burdens of disease.

communication. Previously, a simple matter that could be solved by telephone would mean an officer boarding a bus to Dar es Salaam.

Q: What factors are hindering implementation of the project? .
A: Among them is the low rate of literacy. In the district only about 52 percent of male and 40 percent of women are literate. This makes it difficult for the population to absorb messages and change their behaviour.

Q: How are relationships with local authorities?
A: Very good. When we started some viewed our operations as just another donor project, but its implementation changed perspectives. TEHIP is now seen as a local and central government initiative.

Q: How is health planning done in your district?
A: The basis for planning was the reports from health facilities all over the district. In 1996/97 we incorporated reports of Adult Morbidity and Mortality Project (AMMP) in our plans and since 1997/98 we went beyond the health facility to reach communities as a source of information for planning purposes. In 1998/99, we adopted a Participatory Rural Appraisal initiative to find communities needs and priorities. In a nutshell, communities express their needs, the District Health Management Team reviews them and subsequently forwards the prioritized needs to the District Planning Team, where a plan is shaped and presented to committees of the District Council and to the TEHIP Operations Committee

Q: How free are you to allocate resources according to plans?
A: The District Executive Director is the accounting officer of all funds and we work hand-in-hand to make sure that the funds are used according to the plan. Reallocation of the funds may be done but after being granted permission from the specific funder.

Q: How are the Local Government Reforms likely to affect the project? .
A: The Reforms will definitely enhance the project. The reforms empower the district which is what TEHIP is all about. Actually, we are now implementing the reforms and I guess we are at an advanced stage.

Q: How are you linking up with other programmes?
A: Our links are harmonious especially in view of the fact that I have a role in all the health programmes being implemented in the district.

Q: How is the research office assisting the district?
A: We got very useful data from them last year. The DHMT and the District Health Planning Team utilized the information in developing the 1999/2000 plan.

Q: What have you learnt in the course of implementing the project?
A: I have a wealth of experience. The bottom line is that the communities that we serve are crucial in the success of a programme. We tend to underrate them but their contribution is crucial. Also, team work is the best approach to undertake a task. I would say that I have been effective as a DMO because we have been operating as a team.

What are TEHIP's envisaged outputs which will promote and assist Health Sector Reform?

■ The importance of cost effectiveness and sustainability cannot be understated. Through piloting research and development activities, TEHIP will progressively design and formulate a series of "Tools".

The ultimate tool kit should provide the necessary "components" which could permit all districts within the country to quickly and effectively understand and implement the principles of decentralized health service delivery. Examples under test are tools for cost tracking, community voice, district health budget planning matrix, burden of disease analysis, cost effectiveness analysis.

TEHIP has been designing and formulating a series of 'tools' and the ultimate tool kit should provide the necessary components which could permit districts to understand and implement the principles of decentralized health service delivery. Above, researchers and DHMT members share their experiences on Strengthening Health Adminstration and Resource Management (SHARMS)

IMPLEMENTATION

DHMT: Movers and shakers in health care delivery

The District Health Management Team (DHMT) is an executive body of all health matters in the district. It is multi - disciplinary and has a wide range of functions

Peter Nkulila, a clinical officer and member of the Morogoro Rural District Health Management Team (DHMT) is proud of his job and role in planning but he has some reservations when he discusses about logistics. Moving medical supplies from the District Headquarters to some of the outlying health facilities is often a nightmare in the 19,250 square kilometre district with a dominant mountainous terrain.

"Some facilities have no access road at all," Nkulila said as he narrated about a dispensary in Lumba Chini, in Morogoro Rural which is not reachable by a motor vehicle and therefore not easy to estimate the exact time from the district headquarters.

Supplies to that facility are offloaded at Singisa Mission and a messenger is sent out to scale the rugged mountain to inform workers at the uphill facility of the new arrival. The supplies would eventually be carried by a porter at a fee and not many are enthusiastic to brave the ascent which normally takes at least two hours.

As Morogoro Rural health workers struggle to ascent highlands in order to deliver supplies and discharge other services, some three hundred kilometres away, rowing boats have to be used to reach villages and health facilities surrounded by flood water in Rufiji District. Delivering supplies and supervision work is complicated when the Rufiji River swells and increases its width by about 15 kilometres in some areas. But even when flood water is not posing a challenge, still boats have to be used to reach villages scattered in the Rufiji Delta zone.

Peter Nkulila, a Member of the Morogoro Rural Health Management Team

There are more intriguing stories of the logistic difficulties that have to be endured to reach health facilities in the TEHIP districts.The long rainy season which normally runs from March to May is blamed for many of the woes. The rains wash away sections of the rural roads rendering some of the facilities inaccessible. When they have to use alternative routes in some areas the distance may increase even threefold which means more fuel and man-hours lost.

In view of the logistic problems, both districts DHMTs obtained four-wheel vehicles, motor-bikes and bicycles. Rufiji, with an extensive flood plain, a myriad of wetlands and a delta area, obtained a boat which is used all year round to reach some facilities.

The DHMT bear the burden of ensuring that supplies are delivered to all government health facilities in their district. However, that is not their only test of endurance and concern. They have a more formidable task of ensuring the delivery of high quality, cost effective district health services that takes into consideration equity of access.

Performing their functions without the necessary resources and tools has invariably been an impossible mission. In the project districts, the capacity of DHMTs to be functional and effective has been enhanced. "What we are doing today is implementing ideas conceived many years ago but could not be carried out", said Nkulila.

The core questions of TEHIP in the context of Decentralization...

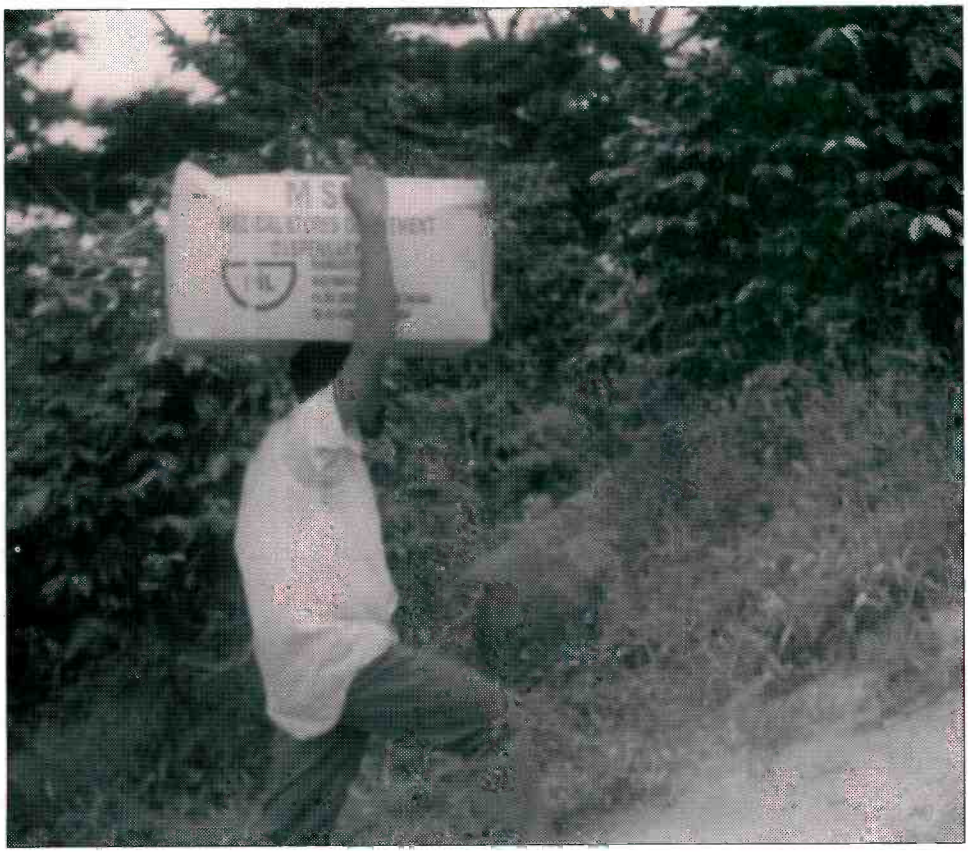
1. How and to what extent can DHMTs do evidence-based planning?

If so,...

2. How and to what extent can DHMTs implement such plans?

If so...

3 How, to what extent, and at what cost, does this reduce the burden of disease?



A villager carries medical supplies to a health facility in Morogoro Rural. One of the functions of the DHMT is to ensure proper management and availabilty of resources such as drugs and medical supplies

Rufiji district: In some parts of the district dug out canoes are the only means of transport during the rainy season

What the DHMT does

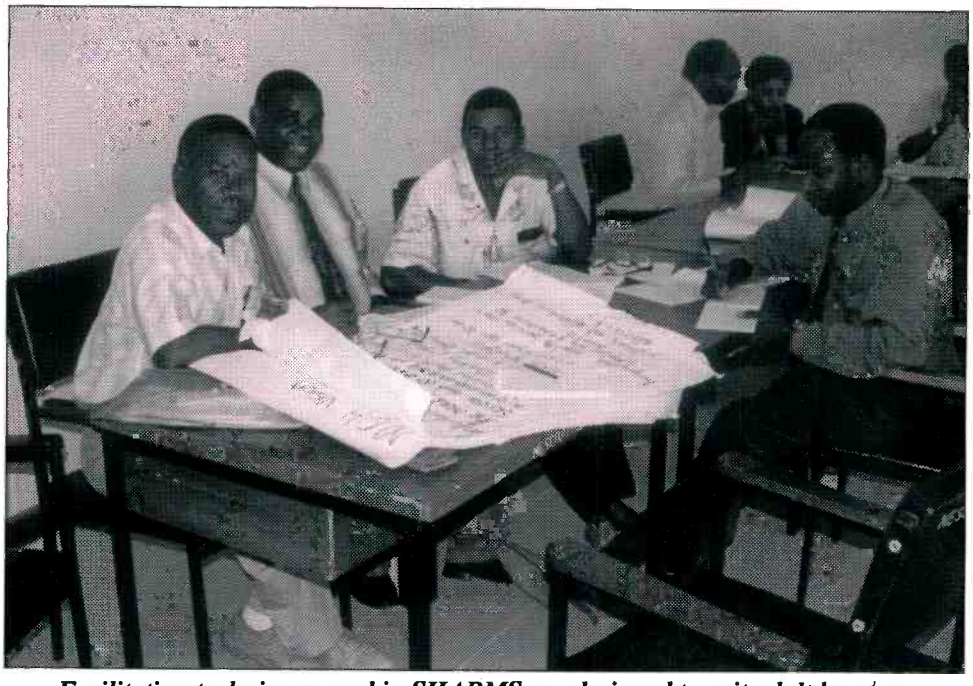
The District Health Managent Team is headed by the District Medical officer. Its functions include:

- Reviewing development plans in the district (including private and NGOs)
- Preparation of annual health plans after consultation with all stakeholders.
- Implementaion of health services based on district health plans and in accordance with national rules and regulations.
- Initiation and promotion of partnerships with other health providers and other sectors to enhance collaboration and partnership in the district.
- Putting in place mechanisms that enhance proper collaboration and communication at all levels of the health service.
- Strengthening health management information to ensure effective use of data for planning and selecting appropriate health interventions.
- Fostering of health system research and analysis in the district and utilization of findings to improve health status.
- Identification of training needs in the district and staff development plan for proper career development of staff.
- Establishing functional committees to enhance community participation especially at health centre, community and household level so as to encourage community participation.
- Monitoring of all health service performance in the district and taking corrective action where required.
- Ensuring proper management and availability on a regular basis of resources within the budget. This includes personnel, drugs and medical supplies.
- Ensuring the support of all initiatives for local mobilization of resources.

IMPLEMENTATION

The challenges of building the capacity of DHMTs in problem solving

The strengthening of health administration and resource management within the context of health sector reforms (SHARMs) project originated from discussions between Tanzania Essential Health Interventions Project (TEHIP) and the Primary Health Care Institute, Iringa. The project was preceded by a rapid training needs assessment among representatives of Morogoro Rural and Rufiji Districts Health Management Teams (DHMTs). The results of the appraisal indicated that there was an immediate need in management support to the two DHMTs focussing primarily on improvement of the capacity of the DHMTs to implement their plans.



Facilitation techniques used in SHARMS are designed to suit adult learners.

The Primary Health Care Institute was commissioned to execute the management support programme following presentation and discussion of a detailed project proposal with the TEHIP management. The strategy that was selected for use in the project was that of building the capacity of DHMTs in problem-solving with regard to day-to-day problems that impede implementation. The strategy or method was in fact an adaptation of the "Strengthening of Health Management" Process as developed by WHO.

The project took off on March 26, 1998 with preliminary visits to each of the districts during which the project was explained to the DHMTs and District authorities. Tentative timetables and other organizational issues were also agreed upon.

Definitive project activities were conducted over a 9-month period, between April 26 to December 31, 1998. Similar sets of activities were carried out in each of the two districts. Thus, initial ten-day start-up workshops were conducted which were followed by two-to-three-month implementation periods. Three-day follow-up visits were conducted in the middle of the implementation periods. Review workshops, also of ten-day duration each, were then conducted after the implementation period following another two to three months of implementation four-day final review

On the whole the project was well received by the DHMTs. The level of active participation by all individuals was high.

Investigators Charles Mayombana (standing) and Ahmed Makemba consult each other in one of the capacity building sessions

Makamba Mbega, a member of the Rufiji DHMT during a Strengthening Health Management workshop.

meetings were carried out.

The project was well received by the DHMTs. The level of active participation by all individuals was high. The main strength of the method is the fact that it enhances problem solving and analytical skills which are qualities required of all managers. For similar reasons, its potential for initiating a sustainable process in health management development is high since the facilitators do not need formal training in management.

Of course, building capacity within the DHMTs to address problem-solving is only one aspect. This entry point has stimulated the identification of other areas of management needs by the DHMTs themselves and has resulted in a "knock-on" effect. The DHMTs now function better as a team than before and hold regular meeting swith agendas and minutes. This has led to more efficient delegation of tasks among DHMT members and thus shared responsibility towards improving district health service delivery. An indication of the success of this practical approach to management skill-building has been the regular production of quarterly financial and technical reports for the district health plans.

In the long term, these capacity building elements, after appropriate pilot experience, will form the essential components of a DHMT management "toolkit". It is envisaged that this will complement the existing DHMT Managment Training Course Modules which will be offered through the Ministry of Health Zonal Training Centres.

ON THE MOVE: Animators promote use of ITNs in communities

The DHMT has provided animators with bicycles to ease their travelling in villages

In order to fight malaria, the number one killer disease in the district, Morogoro Rural District has embarked on the use of Insecticide Treated Nets (ITNs) as one of the most cost-effective strategies towards the control of malaria.

To promote the use of ITNs, the District Health Management Team (DHMT) has identified 85 animators in the current 155 villages covered with the ITNs activities.

The identification of the animators was done in collaboration with village governments. The animators with the co-operation of the peripheral frontline health workers will promote the use of ITNs, encourage communities to re-treat their mosquito nets and respond to their questions or problems that might arise.

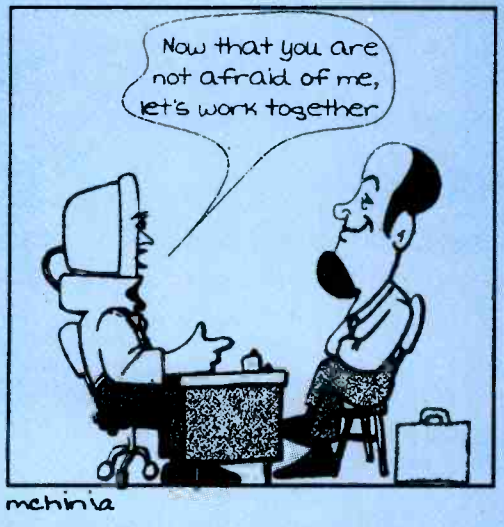
The animators are currently being provided with bicycles to ease the travelling within their localities.

Computers make light work of chores

A.S. Kashindye has reached retiring age but as he was about to bid farewell to the job he has been doing for several decades that was when enthusiasm started and he began to enjoy it. "Now I can complete a month's job within three days and with accuracy," said Kashindye, an accountant with the Morogoro Rural District Council. Ironically, what Kashindye sees now as his best and dependable tool had given him sleepless nights when rumours of its imminent coming spread in the district headquarters like bush-fire.

When it was confirmed in 1997 that computers would be brought to the accounts section of the District Council, he was sure that the technology would dislodge him from his job.

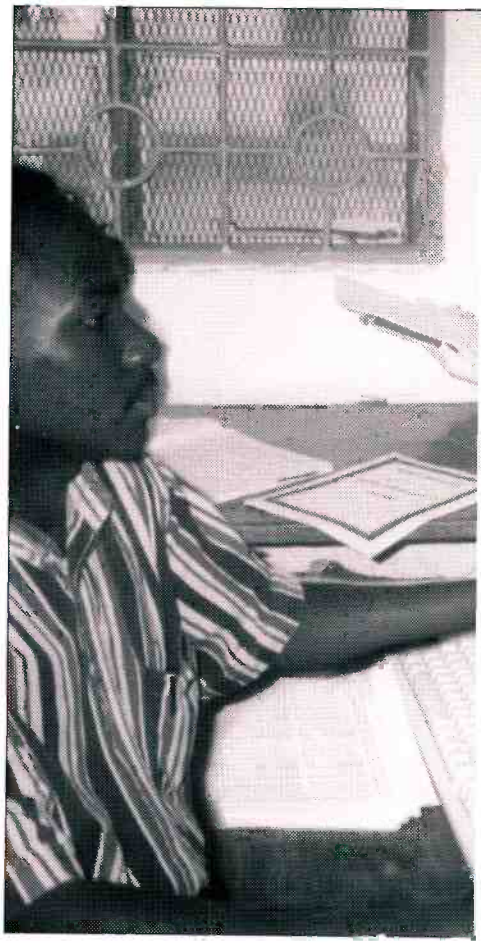
"I was restless because I am not computer literate and I have heard of stories of computers displacing people in work places." he said. But, fortunately, what he dreaded hasn't happened. In his office at the District Council headquarters, are two computers daily churning out accounts figures, budget write-ups and research data for TEHIP and the District Council.



Kashindye now boasts of the marvels of computerization. Although his office has been using computers for a hardly one year, he can't figure out proper accounting and data analysis without the use of a computer. The computer system in his office has, among others, a spreadsheet programme which has made his work much easier. The District Council is now in the process of computerizing its accounting system.

Anecdotes and fantasies of the wonders of computerization are widespread in both districts where TEHIP is undertaking its project. There are no computers at Kibiti health centre in Rufiji district but Ali Msumi, who takes care of all medical records believes that once he gets access to a computer the hardships of keeping records and tallying figures would be over. Had he not visited Ikwiriri, about 20 kilometres from the centre, in recent months he would probably not have been having such imagination. Msumi saw a computer for the first time when he called at TEHIP Research Station at Ikwiriri to deliver cost tracking forms. After a demonstration by a data entry clerk he was struck with awe and then realized that there was a missing tool in his operations. A computer is what he would like to lay his hands on in order to simplify his work. Over the past six months he has experienced an increase of patients coming to the facility, a change which has more or less doubled his workload. His job is also more tasking now than ever as he has to compile information required by the Health Managent Information System

At the time being installing computers at government health centres like Kibiti is still a far cry but TEHIP's initiatives do indicate that it is a viable undertaking. Just as Kashindye's fears have been allayed, so will Msumi's dreams be realized when the process being tested by TEHIP proves positive and their benefits are widely disseminated.



Using reliable information i

Bringing reliable health information to bear on policy and planning in resource constrained countries is still a far cry in the world's poorest countries. For large parts of the world's population there remains a void in vital health information. Without population-based data, health services rarely reach those at greatest risk, many of whom die without any contact with the health system.

The imperative for a reliable information base to support health development has never been greater.

A critical contribution to this is the experience of a limited, but increasing number of field stations which have, as their foundation, continuous monitoring of

Alex Magomi of the Morogoro District Council is one of the personnel trained in data processing.

ealth decision making

geographically defined populations that can generate high quality, population-based, health and demographic data.

These data are able to inform priority setting, policy decisions and the allocation of resources. They also lead to highly focused intervention-oriented, research agenda, including a range of health, social, economic and behavioral studies.

It was against that background that at a meeting in Dar es Salaam, in November 1998, members of field sites based on demographic and health surveillance convened to establish an International Network of field sites with continuous Demographic valuation of Populations and Their Health in developing countries (INDEPTH). Seventeen field sites, drawn from13 countries in Africa and Asia, participated in this constituting meeting. The INDEPTH founding document was drafted, debated and adopted by all member sites, a coordinating committee and chair were unanimously elected, and seven initial workgroups were formed. The prime purpose of the Network will be to substantially enhance the capabilities of INDEPTH field sites through:

- technical strengthening
- methodological development
- widened applications to policy and practice
- increased interaction between site leaders, researchers and managers.

Much of this can be effectively addressed through bringing these field stations into ongoing and effective contact, so providing opportunities to:

- Continually improve the methods and technologies used in resource-poor settings
- Cultivate cross-national activity and broaden the scope of research
- Build capacity at individual and institutional levels
- Strengthen the interface of research with policy and practice
- Improve the validity and generaliza-bility of findings.

Defining characteristics of INDEPTH settings

A geographically defined population (or populations) under continuous demographic evaluation, which allows the timely production of data on all births, deaths and migrations within that population: sometimes called a demographic surveillance system (DSS). This system provides a platform for a wide range of health, social, economic and behavioural studies.

The Indepth Network can be contacted at its Secretariat in Ghana at E-mail: indepth@africaonline.com.gh

Sentinel DSS shows good results in tracking burden of disease

In Morogoro rural district, the Tanzanian Ministry of Health's Adult Morbidity and Mortality and Tanzania Essential Health Interventions Projects (AMMP and TEHIP) work to support the use of evidence in health priority setting and resource allocation. Since 1992, AMMP has maintained a demographic surveillance system (DSS) among more than 300,000 people in three locations, including Morogoro. The DSS, which uses 'verbal autopsies' to determine cause of death, could form one part of a national surveillance system to track the burden of disease.

AMMP records over 2,000 deaths per year in Morogoro among a population of over100,000. 85% of residents live within 5 km of a health facility, yet over 80% deaths occur at home; in 41% of cases, there is no contact with the formal health sector before death. DSS has shown that acute febrile illness (query malaria) is responsible for 44.7% of years of life lost (YLLs) among under fives. Health facility data have routinely indicated malaria as the leading cause of facility attendance, admissions, and in-patient mortality. Despite this, malaria was not given prominence in district health plans or budgeting.

In 1997, TEHIP introduced evidence based planning to Morogoro. This allowed more detailed analysis of the disease burden by District Health Management Teams, who used it to influence priority setting, budgeting and selection of cost-effective interventions. This led to increased investment, selection and delivery of interventions effective for malaria cure and prevention: the Integrated Management of Childhood Illnesses (IMCI) Package, and the social marketing of insecticide treated nets (INTs). To-date, these programmes have reached 75% and 28% of the targeted population for IMCI and ITNs respectively. AMMP and TEHIP continue to monitor this trend toward evidence-based planning, and its impact.

SUPERVISION

Follow-up is key to sustaining improved services

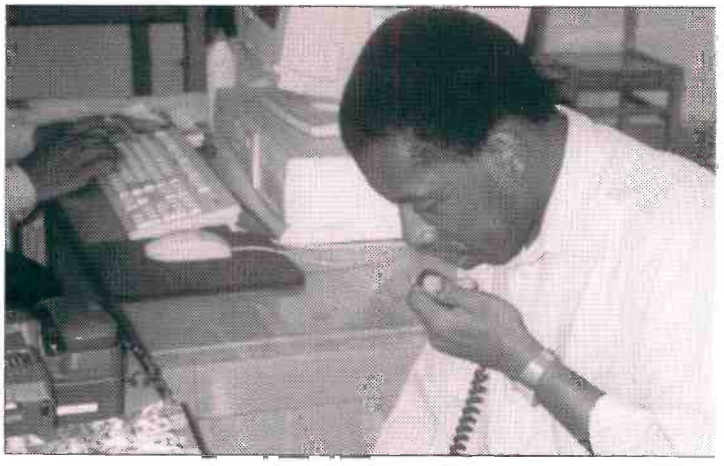
Morogoro Rural district has been implementing various activities that are in their district health plans and much interest has been placed on how the districts could implement their plans and the challenges they could face in the process of translating the district health plans into delivery of the services.

Among the district priorities for the past two years was the Integrated Management of Childhood Illnesses (IMCI) approach. This approach being one of the well-defined interventions in terms of implementation guidelines has been going on in the district since March 1997. Training activities took place in this district and by the end of November 1998, 93 per cent of all health facilities in the district had at least one health worker trained in IMCI.

Follow up of trained health workers was also planned to take place as the training plan was being implemented. The aim was to support the trained health workers to start practicing the IMCI skills in their health facilities with the goal of reducing childhood illnesses in the district.

The approach is aimed at improving management of sick children within and dependent on the existing health delivery system.

After one year it was noted that only 60% of trained health workers were followed up. It was also found that regular supervision was being done with great difficulties.



Regular supervision is crucial and often radio has to be used to keep track of what is going on in the districts.

Since the two activities are complementary, with the regular supervision activity being crucial in sustaining any intervention in the district, there was an interest to look into how best the district could address this problem and sustain the process of improving the delivery of health services through the strengthening supervision in the district.

The 5th session for follow-up after training took place in December 1998. This session

Encouraging signs of a new approach

It is about two years since the implementation of TEHIP started in earnest. The period is somewhat too short to take stock of achievements or failures. In a recent visit to the project area, **TEHIP News** had a chat with health workers and patients on the impact of the project in the delivery of health services. The following are excerpts from their perception:

Tarsis Bwakila, Clinical Officer, Ikwiriri Health Centre:

"TEHIP has contributed enormously in terms of training and improving health services and care. I am impressed with the achievements in attending the under-fives, We have most of the drugs for common disease and the way of managing diseases has improved. Now we take more time to address patients' complaints. A good indicator of improved services is the increasing number of patients coming to our facility.

Shadrack Bushiri, Kibiti Health Centre, Rufiji:

"I have been at the Centre for one year now but I am no stranger to the district's health facilities. I have been working in this district since 1980 and I can easily assess the impact of the TEHIP. We now attend about 150 patients daily compared to 30 to 40 when we used to receive only the Essential Drugs Kits. More patients are coming to us because they know they will be attended well and get the prescribed medicine. We even give some patients appointments to visit us after two days to check their progress. The various courses provided to health workers have been fruitful.

Wilfred Matee, District Nursing Officer and DHMT member, Morogoro Rural:

"It is evident that TEHIP has enhanced coordination in the delivery of health services. Before TEHIP implementation, coordination and communication even among members of the DHMT was limited. With the take off of the project we have witnessed improvement in supplies, infrastructure and even more support from the local administration

Wilfred Matee

Asha Rajabu, Clinician, Ntombozi Dispensary, Morogoro Rural:

"I have been working in this dispensary for the past 10 years and I've seen great changes since TEHIP activities became operational. There are more drugs especially for under-fives compared to previous years. We were using a rundown building erected in 1930s, now the facility has been renovated and we are happier to work in such a facility.

was different from the previous ones because both Follow-up after training and regular supervision issues were being addressed at the same time.

How it was done

One day for preparations was set aside in order to orientate all the supervisors on the regular and specific tasks they needed to perform during the supervision process. Tools used included Follow up after training forms, District supervision forms, and Supervision checklist developed by the PHC being used in Tanga. Three groups of supervisors were formed.

The routes and corresponding number of health facilities to supervise were determined and allocated for each group.

Achievements

There is evidence that the district health system is committed and supports the implementation of IMCI and would like the process of improving district supervision to take place.

Health Facility level

* Procedures in all health facilities have changed in favour of implementation of IMCI and improvement of services in general. Those that have not changed are willing and ready for changes.

* There is readiness for health workers who are not trained to share tasks with good quality after orientation from trained health workers. Equipment and drugs have been made available by supplementing health facilities with EDP kit drugs including those needed for IMCI, STD and HIV prevention, Family Planning, Malaria management, Insecticide Treated Nets and TB/Leprosy drugs in some health facilities.

Health worker skills

Health worker skills have improved in relation to management of the sick child, STD and HIV prevention, Family Planning, Management of malaria, cost tracking and some in the knowledge about the INDENT system. This is due to the training sessions that took place in 1998 related to the mentioned interventions in the district.

Rational drug use

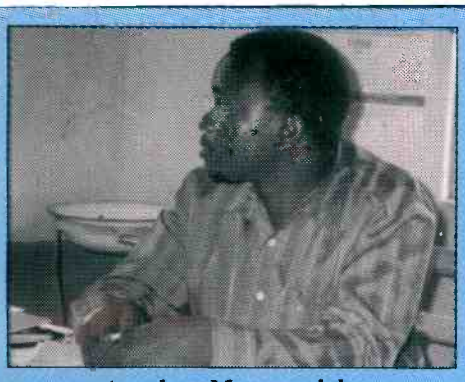
IMCI information collected though special forms indicate that trained health workers who are practicing the learnt skills have good rational drug use attitudes. This can be easily reflected in their well kept records. The majority of health workers visited are practising rational drug use. That is using the right treatment correctly for a particular illness.

Interaction with the community

Interaction with the community is very good especially for those who have been in contact with health workers in the facilities during illness of their children mothers appreciate the improved services being provided.

Problems

Among problems that surfaced is the overlap of activities in the district health plans including supervision plans and schedules. Planned activities schedules were not adhered to due to various reasons. DHMT is overburdened by other activities like training,supervision,planning administrative issues, leave and other unavoidable circumstances. With regard to supervision, some health workers are not visited for very long periods by the DHMT. Distances from the central district level to some health facilities are long and the roads are often not passable.



Amadeus Mwananziche

Shadrack Bushiri

Tarsis Bwakila

Amadeus Mwananziche, Medical Assistant In-charge, Mlali Dispensary, Morogoro Rural

I have worked here since 1995 and the changes are clear. In the past one year or so we have been receiving supplies of medicines especially for under-fives. Adults supplies have also increased because what we don't use for children increase stocks for adults.

The training which received in MCI and other areas has helped us a great deal in the management of various diseases. I guess mortalities have been reduced in this area. Since January this year (Interview conducted on April 14, 1999) only one infant dealt.

Dr. Ferdinand Fupi, Regional Medical Officer, Morogoro Region: "I am grateful having the project here. Delivery of health services and care in Morogoro Rural District is unparalled in the region's districts. The district has been able to write a comprehensive health plan. Plans of operation now exist and are monitored. There are many changes that are explicit, for example, the DHMT capacity has been enhanced; support in terms of funds, transport, and communication means, hence articulated, elaborate data collection that facilitates early warning of outbreaks, and rehabilitation of facilities. There is community involvement going with the changes hence there is no doubt of the benefits and efficacy.

SERVICE PROVISION

Facilities attract more patients

For the past four years, twenty-five year-old, Mwanaisha Saidi has been attending the Ikwiriri Health Centre whenever she experienced health problems. During the rainy season, she uses a dug-out canoe to wade through swamps and subsequently ride on a bicycle back seat, as a passenger, to cover the 24-kilometre distance between her village and the health centre. On April 16 this year she waited three hours in the queue to see a doctor but she did not regret the long wait. "Eventually I got attended and received the medicine that will cure my ailment," she said.

Ms Saidi has an option to go to a Mission Hospital about one kilometre from the health centre commonly known in the area as "Kwa Wazungu" where she could be attended within a much shorter time, but she cannot afford the user fees charged there despite the fact that they are heavily subsidized.

In both Ikwiriri and Morogoro districts, patients are flocking to government facilities that had previously been frowned at by patients due to unsatisfactory services and lack of drugs. For many years dispensaries, and health centres depended on Essential Drug Kits uniformly packed with an assortment of drugs deemed essential for every district in the country.

In many facilities, the one-month supply would last no more than 10 days and during the rest of the month, patients would only be given prescriptions and advised to buy medicine elsewhere. In the rural areas where pharmacies do not exist, patients found themselves in dire situations and many did not see any sense in attending the medical facilities.

In the wake of the initiatives being implemented by the government in collaboration with TEHIP, health facilities in Rufiji and Morogoro Rural districts are increasingly attracting large numbers of patients. Many of the facilities now attend between 150 to 200 patients a day whereas prior to the initiatives hardly 50 patients a day were attended. According to Asha Rajab, a clinician at Mtombozi Dispensary in Morogoro Rural District the facility remains open for about 12 hours during week-days in order to cope with the increasing number of patients. The situation is more or less the same in most of the facilities covered by the project.

Many patients do acknowledge improvement of services and care in the facilities. Nineteen year old Salima Mohamed of Kipera Village in Morogoro is already a mother of two and has been attending Mlali dispensary since 1994 but never quite appreciated the facility services. She was also disgusted by "We don't have this medicine here" remark. She decided to attend a dispensary at the Institute of Development and Management at Mzumbe but now she's back again to her old facility. Reason: "I get better service and free medicine here."

The DHMT allocates funds for IMCI drugs, equipment and supplements to the Essential Drugs Kit distributed by the Medical Stores Department. The drugs related to IMCI and the supplements are distributed to health facilities according to district demands processed at the Medical Stores Department.

At Kibiti Health Centre workers have noted an increase of patients since implementation of TEHIP started.

A clinician at Mtombozi Dispensary. More rational use of drugs has been observed

ASSESSMENT

Efforts to combat major killers start to pay off

On May 3, 1999 the Minister for Health, **Dr. Aaron Chiduo** opened a World Health Organization Workshop on Expansion of Integrated Management of Childhood Illnesses (IMCI) in the African Region. The three day workshop discussed a wide range of issues aimed at improving implementation of IMCI so as to reduce childhood mortality and increase growth and development. The following is an excerpt of his speech:

In Tanzania, like in many other African countries, the main causes of death in children are malaria, diarrhoea, pneumonia and malnutrition. IMCI tries to tackle these major killers of children, through prevention and treatment, by using the IMCI strategy which has three components:

1. Improving case management skills of health workers through provision of guidelines on integrated management of childhood illness, training and follow-up of trained health workers.

2. Improving health systems to support effective case management by:

- Ensuring availability of essential drugs and other supplies;
- Improving organisation of work in health facilities;
- Improving referral pathways and care;
- Improving monitoring and supervision.

3. Improving family and community practices.

The strategy brings together improved case management with aspects of nutrition, immunization and several other influences on child health, including maternal health.

The first global pretest or trial of IMCI took place in Arusha in February 1995. Using the experience from that workshop, the generic WHO/UNICEF materials were finalised, which are used for local adaptation all over the world now.

Tanzania was one of the first countries in Africa and in the world, which started training sessions on IMCI, in 1996. The materials have been adapted to our situation, and translated into our language, Kiswahili. The early implementation phase started in September 1996 with the first Master Training. This was followed by training and follow-up visits in 7 districts: Mpwapwa, Morogoro Rural, Rufiji, Magu, Korogwe, Muheza and Igunga.

In May 1998, we had a major review and planning meeting. The outcome was a 5-year strategic document and a 2 year plan of action. This meeting was the start of the expansion phase. To-date to date over 700 health workers have been trained in 15 districts. We even assisted our neighbouring

Integrated Management of Childhood Illnesses is one of the Essential Health Interventions Packages in the National Health Sector Reforms. In the project districts, like the rest of Tanzania, Malaria is a main cause of death for both children and adults. Above a woman and her two children wait for diagnosis at the Ikwiriri Health Centre.

Improved services

continued from page 15

countries by starting IMCI training for health workers in refugee camps, which house refugees from Burundi, Rwanda, and the Democratic Republic of Congo.

In order to expand more quickly, IMCI has also been introduced in the curriculum of 5 of the 20 schools for AMO's and Clinical officers. This effort will continue to cover other training institutions.

During follow-up visits in their facilities it was found that most of the trained health workers are implementing properly what they have learned, and therefore the services of our facilities have improved.

Tanzania Government's key partners in IMCI implementation are WHO, UNICEF, GTZ, TEHIP, the Christian Social Services Council, and the World Bank.

The IMCI strategy does not only involve training and follow-up visits, but also improving health systems support and community and family practices. This will only be possible through cooperation with other ongoing developments in the health sector.

Tanzania is undergoing a process of National Health Sector Reforms. The main objectives are equity decentralisation and cost-sharing. IMCI has been selected as one of the Essential Health Interventions Packages in the National Health Sector Reforms. therefore the IMCI strategy and the National Health Sector Reforms will mutually support each other.

Besides implementing IMCI within the country, Tanzania has also been hosting several international IMCI activities.

Currently Tanzania has been chosen as the site for the global study on the impact of IMCI in two districts, Morogoro Rural and Rufiji.

From the experience of IMCI in our country and in these international meetings, we learned that there are many challenges remaining in order to expand IMCI. Firstly, capacity building in the districts is needed. Then we are working hard on improving drug system, and supervision. Most important will be implementation of the household family and community components which will improve child care practices, care seeking behavior and increase the utilisation rates of the health facilities.

IMCI restores confidence of care givers

The integrated Management of Childhood Illnesses (IMCI) Regional Task Force met in Harare, Zimbabwe from June 22-24 this year to re-examine the IMCI strategy and devise practical solutions to problems that are likely to be dealt with in the next Millennium.

*IMCI has become **A Best Practice** in child health in the few years of implementation in the WHO African Region*

The World Health Organisation African Regional Director, Dr. Ebrahim M. Samba, told members of the Task Force that IMCI in the African Region was taking the lead globally. He said "In the few years of its implementation in our Region IMCI has become "A Best Practice" in child health". Twenty eight countries are currently at various stages of implementation of IMCI. Improvements have been reported in the quality of care provided by the 3,000 IMCI-trained health workers in their facilities.

"Such success would not have been recorded but for the support that we receive from all our partners - USAID, DFID, the World Bank, UNICEF, GTZ, TEHIP and AVSC - to name a few," he said. IMCI is ranked among the first ten interventions that are capable of reducing the global burden of disease and improve equity. Its relevance hardly needs emphasis in the African environment where inequity, poverty and disease prevail.

Dr. Samba also said the improvements, undoubtedly restored the confidence of the care-givers in the Region's health services. WHO/AFRO has developed a strategic plan for the accelerated implementation of IMCI for the year 2000-2005.

Three members of the TEHIP management team - Dr. Harun Kasale, Dr. Graham Reid, and Dr. L.D. Mgalula attended the Task Force meeting during which they shared with others their experiences in the implementation of IMCI district support.

TEHIP News

TEHIP News is a development oriented newsletter published by the Tanzania Essential Health Interventions Project. 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 News hopes that it 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 web site: http://idrc.ca/earo/. To be included on our mailing list write to:

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Printed by Zek Printers Ltd. Dar es Salaam