United Republic of Tanzania
Ministry of Health and Social Welfare

# Mid Term Review of the Health Sector Strategic Plan III 2009-2015

## Lindi Region Field Visit

**October 2013**

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# Mid Term Review of the Health Sector Strategic Plan III 2009-2014

# Lindi Region Field Visit Report

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# 1. Introduction

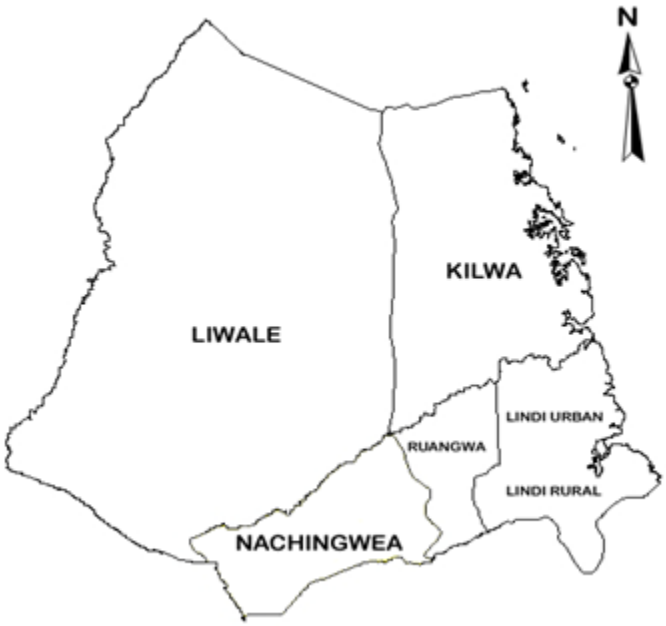
The Mid Term Review teams for the Health Sector Strategic Plan III (HSSP III) visited three regions – Geita, Lindi, Mbeya - to assess progress and challenges on the ground. Field visits were guided by a common checklist to ensure comprehensive coverage of the main HSSP III strategies and three additional areas of importance.

This report provides the findings of the visit to Lindi Region. During the 6-day field trip the team (see Annex 1) visited Lindi Municipal, Lindi Rural, and Kilwa councils. Meetings with the Regional Health Management Team (RHMT), Council Health Management Teams (CHMT), Hospital Management Teams (HMT), and staff from health centres and dispensaries were held (see Annex 2 for list of those met). The findings provide a snapshot of progress and challenges as reported by the interviewees. Time constraints did not allow performing an in-depth assessment that would yield deeper qualitative or quantifiable results. The field trip took place from 21 to 26 July 2013.

# 2. Region Profile

Lindi Region is found in the south-eastern coast of Tanzania. The Region is composed of six administrative districts: Lindi Municipal Council, Lindi District (Rural) Council, Kilwa District Council, Nachingwea District Council,, Liwale District Council, and Ruangwa District Council,. The region's total area is 67,000 km2 and about one quarter of this area approximately 18,000km2 is part of the Selous Game Reserve. About 5,250,000 hectares in the region are suitable for crop cultivation and about 10% of this is cultivated. The vegetation consists of small and fragmented coastal forests. About 10% of the total area of Lindi Region is forest reverse out of which 6,958 km2 is a national reserve and 170 km2 is under district councils.

**Figure 1: Regional Map**




Coastal climate prevails in Lindi region and it is generally hot and humid. There are four drainage basins suitable for cultivation in the region. Fish is the main source of protein. The economy of the region centers mainly from crop production characterized by smallholder cultivation. Maize, Cassava, rice and sorghum are the important food crops while cash nut, simsim and coconut are mostly grown as each crops. Administratively, the region is divided into five districts with its population, Divisions, Wards and villages summarized in Table 1.

**Table 1: Number of Divisions, Wards and Villages in Lindi Region**

| S/NO | Councils Name | Population Size | Number Of Divisions | Number Of Wards | Number Of Villages |
|---|---|---|---|---|---|
| 1. | Lindi Municipal | 75,102 | 1 | 18 | 20 |
| 2. | Lindi D.C | 262,569 | 10 | 30 | 134 |
| 3. | Ruangwa | 154,899 | 3 | 21 | 89 |
| 4. | Liwale | 94,595 | 3 | 20 | 76 |
| 5. | Nachingwea | 202,742 | 5 | 32 | 126 |
| 6. | Kilwa | 188,748 | **6** | **21** | **96** |
| | Total | **978,655** | **28** | **122** | **511** |

Source: NBS census (2002) Regional and Lindi Profile 2012

Extrapolating from the 2002 census using the NBS figures, for the year 2013, the Region is estimated to have a total population of 978,655 of which 28% live in urban and 72% in rural area. Basing on 4.1 as an average size per household, Lindi is estimated to have a total of 190,761 households, 59,361 being in urban while 170,367 households in rural area. Vital statistics of the region are shown in Table 2.

**Table 2: Lindi Vital Statistics**

| INDICATOR | REGIONAL VALUE 2011 | NATIONAL VALUE |
|---|---|---|
| Total Fertility rate | 3.93/Woman | 5.7/Woman |
| Crude Death rate | 12.2/1000 | 12.31/1,000** |
| Crude Birth rate | 31.8/1000 | 33.44/1,000** |
| Population Growth rate | 1.85% | 2.9% |
| Maternal Mortality rate | 141/100,000 | 454/100,000 |
| Infant Mortality rate | 71.5/1000 | 68/1000 |
| < 5 Mortality rate | 122.6/1000 | 112/1000 |
| Life Expectancy | Overall: 56.8 YRS | Overall: 56.8 YRS |
| | Male: 57.3 | Male: 53 Yrs |
| | Female: 60.7 | Female: 56 Yrs |
| Population composition | Male: 51.8% | Male 48.9% |
| | Female: 48.2% | Female 51.1% |
| Literacy rate | 65% | 62% |

Source: NBS census (2002) Regional, District projection Vol XII, of 2006 and HSSP III.

** Source Index Mundi – Country Facts

# 3. District Health Services

## 3.1 Findings

**Awareness of HHSP III** appeared to be limited at District Hospital (Lindi Rural and Kilwa) level, and this dropped off quickly to even lower levels at CHMTs, Health Centers and Dispensaries visited.

**The Essential Health Package** was reported by all (acting) health facility in-charges to be fully integrated into all service delivery provided. Strong international partnerships in mainly vertical disease control interventions were also reported at all District Hospitals, Health Centers and even most Dispensaries visited. These included Elizabeth Glazer Pediatric AIDS Foundation (EGPAF), International Center for AIDS Care and Treatment Programs (ICAP) and Axios for HIV/AIDS care and treatment, MEDA Tanzania for malaria control, Save the Children UK for TB & Leprosy DOTS, and IMA WorldHealth for NCDs. Immunization service delivery collaboration with UNICEF and WHO appeared to be very strong. Non-communicable disease service provision was limited to diabetes and hypertension clinical services at Health Center and District Hospital OPD.

Annual **CCHP** preparation appears to be one of the most structured planning & management actions at CHMT level particularly with preparation and technical support from the Lindi RHMT. This applies as well to the quarterly reporting requirements from CHMTs to RHMTs to MOHSW and PMO-RALG at national levels. CHMTs and the RHMT also referred to direct communications and technical support from the District Health Services Unit at MOHSW (Dr. A. Nswilla). Regular **supportive supervisory visits** by RHMT to CHMTs and from CHMTs (and less often by RHMTs) down to Health Center/Dispensary levels for contributions to CCHP planning, quarterly reporting inputs and provision of vertical disease control technical advice was consistently reported throughout all Lindi health committee and HF visits.

The **Tanzania Quality Improvement Framework (TQIF),** as issued by the Division of Health Quality Assurance, MOHSW, was unknown as a national program *per se* in those teams and HFs visited in Lindi Region. However, District Hospitals did refer to Quality Improvement Teams (QITs) being in place and active with a focus on infection protection and control (IPC) as per separate national MOHSW guidelines.

None of the CHMTS or District Hospital in-charges met were aware of the national **Hospital Strengthening Program.** One DMO reported participating in a discussion on approaches to HF accreditation with MOHSW colleagues who visited the District Hospital in 2010.

The most common community strategy activity referenced by CHMT, DH and Dispensary teams was the presence of **Health Facility Governing Committees (HFGCs).** However, in almost all cases, regardless of level, when probed further on confirmed activity levels of the committees, it was understood that lack of sitting allowances for HFGC members was proving to be a demotivator to regular attendance. Most HFGCs reportedly met on average only twice a year at best, rather than the stipulated quarterly schedule. It was not clear how active Ward and Village Health Committees were but in at least one District (Kilwa), they were reported to be completely inactive due, in part, to a "lack of volunteerism" at ward/village level.

Most DHs, HCs and Dispensaries reported **staffing levels** improvements over the past 3 years but this still only meant that 50-60% of their full complement in 2013 were actually filled. Regardless, there appeared to be no major complaints over same period, i.e. from 2009 – 2013. Shortages in key clinical

staff positions (MOs, AMOs, CO, Nurses, Pharm technicians and Lab technicians) were a consistent and repeated concern by HF in-charges. Insufficient staff housing was reported as one of the largest staff retention issues faced by district health service managers in Lindi Region.

**Staff workload** overall at DHs, HCs & Dispensaries were reported to be generally increasing over past three (3) years but most HF workload levels were generally moderate to above moderate levels against the available staffing levels (unadjusted however for the high proportion of unskilled nursing/health attendant staff, especially at HCs and Dispensaries). HMIS reporting - some HFs referred to 10 books + 9 others per month to complete, with no workload-related complaints.

## 3.2 Conclusions

An observed key issue behind all District health service provision in the Region is the dilemma resulting from a clear MMAM objective to expand the number of rural HFs on the one hand, and available funding to meet the added recurring costs (mainly staffing and medicines/supplies) to maintain a larger number of HFs on the other.

Further, there appears to be a high level of financial, technical and logistical dependence on Global Health Initiative (GHI) partners (i.e., PEPFAR, PMI/RBM, Stop TB) to CHMTs and DHs in the planning, implementation & monitoring of the five main communicable disease control programs: HIV/AIDS, malaria, TB/Leprosy and NTDs.

Basic knowledge and understanding of TQIF, PPP and EPR at Lindi council/district levels and below are weak at best. HFGCs are only barely functioning as per their TORs in the Region. Their TORs, funding options & training needs appear to require an overhaul from Regional to Dispensary levels.

The role and function of CHMTs versus District Hospital Management Teams was not always clear in separate discussions with both sets of teams. In addition, as both the RHMT and CHMTs provide supportive supervision visits to District Hospitals, Health Centers and Dispensaries, these may need improved RHMT-CHMT coordination (are there too many per quarter now?) as well as a clear procedure for referral back mechanisms where needed.

# 4. Referral Hospital Services

## 4.1 Findings

Both the RHMT and RRHMT are aware of **HSSP III** and reported using it for annual planning purposes. The 2007-17 MMAM was not clearly referenced.

A lack of role clarity appeared to be evident between **the RHMT and the Lindi RRH Management Team.** This might be attributed to both a lack of a separate physical space for the RHMT to work, i.e. separately from the Regional Referral Hospital, and a high level of co-opted RHMT members from the RRH Management Team. Some Lindi RHMT members reported wanting to stay operational on RRH premises for "ease of communication" with clinical peers rather than be housed at the RAS compound some distance away from the RRH. Possibly as a result of the above blurred role definitions, supportive supervision visits by the RHMT to the Lindi RRHMT were not frequent over the past 3 years.

Neither the **Hospital Strengthening Program** nor the **TQIF** were known to the Lindi RRH Management Team. However, the Regional Hospital reported having a Quality Improvement Team (QIT) in place addressing mainly infection prevention and control (IPC) issues for the facility as well as some applications of the "5S Kaisen" approach.

Three members of the **Regional Hospital Health Services Board** reported being unsure whom the Board was accountable to, MOHSW or PMO-RALG. They were not aware of their own TORs and had no knowledge of HSSP III. Further, they indicated that they had rarely met over the past year due to absence of sitting allowances or "motivation", reportedly provided by GIZ up until 2012.

The **RRH effectively operates as a District Hospital** in at least two respects: first, as there is no District Hospital as such in Lindi municipal, for provision of DH-level HIV/AIDS, EPI, FP & MNCH services; second, there is only one clinical specialist at the RRH. Further, there appeared to be no clear referrals guidelines in operation at the RRH, with considerable bypass events commonplace from both Dispensaries and HCs straight to the RRH (presumably for reasons indicated above).

## 4.2 Conclusions

The Lindi Regional Referral Hospital overall clinical capacity is weak as there is only one specialist. Opportunities exist for improved clarity between the RHMT and RRHMT role, as well as clarified terms of reference and reactivation of the RRH Services Board, which seems to be virtually dormant due to "motivational" issues (e.g. sitting allowances). Despite no apparent awareness of the national level TQIF, there is an operational RRH QIT which reviews IPC and "5 S Kaisen" activities within the Hospital.

# 5. Central Level Support

There is regular, direct communication between the District Health Services Unit, MOHSW, and CHMTs in Lindi Region during CCHP planning and preparation of subsequent quarterly reports. This appears to be parallel to similar communications from the RHMT and CHMTs. In addition, CHMTs and District Hospitals sometimes receive supplies directly from MOHSW. In addition, there are disease programme specific supportive supervision visits (e.g. NACP) from central programme officials (which usually include an RHMT member) to the districts. In general, CHMTs in Lindi Region communicate directly with MOHW during CCHP and quarterly report preparation, in addition to similar discussions during supportive supervision visits from the RHMT.

# 6. Human Resources for Health

## 6.1 Findings

*Production and Training centers*: There is one training centre in the region at Lindi Clinical Officer Training Center (COTC). However at Nyangao Designated District Hospital there is a plan to establish a Certificate training school for nurses. Generally pre-service training is centralized with selection of students, curriculum development, assessment of students conducted at MOHSW Headquarters. Student enrolment and teacher capacity has increased and the curriculum is competence based - an initiative supported by I-TECH. Students pay user fees, which are 20% of total school running costs. Funding from the MOHSW is not adequate and is not disbursed in time resulting in large debts at the COTC. Also the library, classrooms and infrastructure are not adequate for training and the school does not have a vehicle. The Training Institution Information System (TIIS) was introduced to the training centre by University of Dar es Salaam Computing Centre (UCC) and the MOHSW. The school finds this system useful to record all its data.

*Continuous Professional Development (CPD):* Some continuing professional development takes place to some health workers in some facilities. CPD is conducted by the MOHSW, ZHRC and partners through vertical programmes. The RHMT and CHMTs also budget to fund both long and short courses for some of their staff. However these courses are not well coordinated. Also some staff, especially in the rural facilities, complain that they are not selected for refresher courses and that requirement to have a Form Four Certificate is a hindrance for their involvement in CPD. There are no credits offered after training and Professional bodies are not in touch with health staff for CPD.

*Availability of Health Workers (Recruitment, Retention and Distribution)*: As indicated above, the number of health workers working in the region in the recent years has increased. Improved communication, infrastructure, e.g. tarmac road from Dar to the South has made Lindi more attractive to health workers in the recent years. Also salaries to staff are paid on time. However the recruitment process is long and mostly determined by POPSM and MOHSW. Staff requirements are not met as there is reduction of vacancies through the process and eventually they get only 25% staff recruited compared to those requested. Staff establishment often relies on the 1999 Staffing Guideline, which does not consider staff workload. There are no attraction or retention strategies for health workers and the distribution of health workers is not even, with less staff situated in the rural facilities compared to urban centres. Also there are fewer staff in cadres such as pharmacist, dentists, lab technicians, doctors and specialists. Some specialist doctors are employed in administrative positions while the regional hospital and DDH referral hospital lacks specialists.

*Performance of health workers:* Performance of health workers is varied in health facilities. The performance of health workers has improved to some extent because of increased workforce and with relative improvement in availability of drugs. However there is still increased workload due increased activities e.g. at MNCH services and where there are few health workers especially in the rural area. OPRAS is conducted in some districts at district level and in other facilities while P4P is not practiced due to lack of funding. Supervision to health facilities is conducted by RHMT, CHMT and programme staff with varied frequencies but more frequently by vertical programmes coordinators.

*Information system for health workers*: The HRHIS has been established and the District heath secretaries in Lindi are familiar with the system. Recorded HR is found useful to plan and operate HRH functions. However this system is different from the system used by DHROs who uses the PMO-RALG system.

Similarly Nyangao Hospital uses another HRHIS brought to them by Christian Social Services Commission (CSSC).

## 6.2 Conclusion

In general there are considerable challenges in HRH in the Region. The accreditation processes for schools is not efficient and there are no supervision conducted to the training school from the ZHRC or MOHSW. There is a funding gap (approx 25%) from MOHSW. CPD is inadequate, not coordinated and there is no system for providing credits to participants after training. Also professional bodies are not in touch with their members. There are no clear criteria of assessing HR needs in the region and no yardstick to measure staff performance and quality. The MOHSW and PMO-RALG information systems are not linked causing inconsistent information and considerable workload to health workers.

# 7. Healthcare Financing

## 7.1 Findings

**Sources of funding** include the Health Block Grant, the Health Basket Fund, vertical programme funds, and income from cost sharing. District hospitals also operate drug revolving funds, where medicines are sold at cost plus a 10% mark-up. None of the three councils visited have other programmes or plans for generation of additional funds.

A general concern expressed in all three districts is the delay in disbursement of the Health Basket Fund, which delays implementation of planned activities and procurement of medicines. In addition disbursement of the Health Block Grants is usually only 25-50% of the approved annual budgets. Use of the funds can also be delayed because the EPICOR system for administration of procurement processes needs a high-speed internet connection, while internet connectivity is unreliable and slow. Councils further feel that there are too many restrictions on how funds can be used (e.g. 60% for medicines and 40% for renovation/maintenance for the Health Basket Fund). This restricts flexibility to invest in programmes such as non-communicable diseases.

CHMTs knew about the **resource allocation formulas** but these were said to favour urban districts with high population (in particular Dar es Salaam).

Funds for construction in the context **MMAM** are received, but are too little and "do not match the policy".

There is low enrolment in **Community Health Fund** (CHF)/TIKA (e.g. 1.4% in Lindi municipal council) and annual contribution range from TZS 5,000 to 10,000 /family of six. Reasons given for low enrolment were high poverty levels, low user fees charged at health facilities, unavailability of medicines, and limited understanding of the benefits by the community. There are no Council initiatives to subsidise enrolment of the poor, but there are provisions to pay the annual fee in instalments. Because of the low enrolment the threshold for receiving matching funds has never been met in any of the three Councils and consequently matching funds were never received. Another obstacle mentioned was the fact that there are no designated accounts for the CHF – the Councils' 'miscellaneous' accounts are being used.

The general level/importance of **user fees** differed between the health facilities visited. Charges for outpatient visits (including medicines) varied between TZS 1,000 and 5,000 at health centres and dispensaries. User fees are paid into the health facility account. The procedures for using income from user fees were said to be cumbersome (starting with approval by the Village Health Committee and Health Facility Governance Committee through to final approval by the District Medical Officer and the District Executive Director. However, all health facilities do use these funds.

Membership of the **National Health Insurance Fund** (NHIF) is widespread and the system was generally said to be working well. Capacity gaps at health facility level are a challenge as mistakes in completing the claim forms happen. Therefore claims are frequently not honoured in full (one health facility reported never having received anything). Having a regional NHIF office in Lindi is speeding up claim processes for Lindi Councils.

One **Designated District Hospital** was visited in Lindi Rural Council. The hospital faces problems because it is not known how to recover income lost through application of the government's exemption and waiver policies. Lack of budget ceilings for planning purposes was another challenge mentioned.

The **three Councils are using the six accounts**. Once CHMT mentioned that this was a challenge because these accounts are not only for health, administration is difficult, and it can take long to receive funds.

All Councils perform annual internal **audits** and external audits when scheduled (CAG). Audits usually include comments, which are addressed by providing additional explanations. There were no outstanding issues related to audits.

## 7.2 Conclusions

The strategic objective of enhancing complementary financing does not seem to be on track. CHF/TIKA membership is not increasing and there are no specific efforts to increase enrolment by the poor and vulnerable. CHF membership does not cover alternative service providers (e.g. for purchase of medicines out of stock of public facilities).Added value is not clear and the perceived low service quality is a disincentive for prospective members. In addition, there seem to be no incentives for health facilities to increase membership (no benefits from CHF money; matching funds never received).

Funds from NHIF and user fees are more relevant. However, long procedures and capacity gaps in terms of claim preparation and governance (HFGCs, VHCs, WHCs) make effective local use of these funds difficult.

The delayed disbursements of Health Basket Funds impact implementation of Comprehensive Council Health Plans. We could not identify specific strategies to improve planning/reporting of Council actors so that Health Basket Fund disbursement triggers will be achieved timely. There might be room for efficiency gains in the overall planning and review processes.

# 8. Public Private Partnerships

## 8.1 Findings

Among all the Lindi Regional and Council level health committees and health facilities visited, the only tangible aspect of the MOHSW Public Private Partnership initiative are Service Level Agreements (SLAs) between CHMTs and FBO operated District Hospitals or Dispensaries. All other national PPP policy or framework references are not known by the Lindi RHMT, RRHMT, CHMTs, HCs or Dispensaries.

The only exceptions to this were i) the Lindi RHMT self-acknowledged role to "advocate for PPPs between [FBO] District Hospitals and Councils", and ii) the recognition by Lindi municipal CHMT that more private for profit (PFP) services are being established in Lindi town (e.g., eye clinic, pharmacies, dispensaries), which sometimes are provided with free vaccines and FP commodities from the CHMT.

The Lindi Rural CHMT reported involvement with SLA with Nyangao Designated District Hospital (DDH). This agreement was signed off by Lindi Rural DED and central MOHSW PPP Coordinator and Roman Catholic Bishop.

## 8.2 Conclusion

Given the evident lack of awareness at Regional or Council levels in Lindi, there is probably wide scope for more PPP fora nationally at Regional/Council levels. Further, there is scope for expansion of PPPs with PFP health entities at least starting in urban centers within the Regions.

# 9. Maternal Newborn and Child Health

## 9.1 Findings

*MMR and Neonatal mortality:* Maternal mortality and neonatal mortality are still high in the region despite increased MNCH services. In Lindi Municipality the rates went up after the Municipality area was extended to include the rural area. There is an increased use of MNCH services by clients including increased ANC visits and under five attendances for vaccinations, FP, weighing of babies, treatment of diseases, DTC and HIV/ AIDS services. These services are now better due to availability of supplies and more human resources especially is urban centres. Some reported that the reporting forms are also adequate and that supervision are regularly conducted and that they get refresher courses. In some centres the infrastructure for such centres has also been improved. However some rural based facilities are overwhelmed by workload and the reporting process takes considerable time. Most of Municipal MNCH services are conducted at the Lindi Regional Hospital because the municipality does have their own hospital. As such supplies and data are exchanged between the RRH and Municipality.

*Community based MNCH services:* Community based health services through outreach are rarely conducted. The long distances, lack of transport and shortage of human resources is a major hindrance to conducting community based MNCH services. Where community based MNCH services are conducted there is either transport or sometimes workers walk on foot. CHWs were not commonly mentioned to support community based services.

*Emergency Obstetric Care:* CEmOC is reportedly conducted only at the Regional Hospital and District Hospitals. BEmOC services are conducted in some HCs and in very few dispensaries. Generally health workers in HCs and dispensaries have not been trained in EmOC services. Also some HFs visited had only some of the six signal functions required to conduct BEmOC services.

# 10. Prevention and Control of Communicable and Non-Communicable Diseases

## 10.1 Findings

The Lindi RHMT was very well informed on the disease specific programs in Region, clinical and programmatic **national guidelines** from MOHSW, the full array of international and national partners, i.e. mostly Global Health Initiatives (GHIs), and respective levels of policy, technical and QA support from central MOHSW.

**HIV/AIDS** care and treatment services offered appear heavily partnered at DH, HC & Disp levels with EGPAF, I-CAP, and AMREF for VCT, PMTCT, ART and HIV+TB. Reported main HIV/AIDS care and treatment challenges include loss to follow-up with ART enrolees, and staff shortages at Health Center and Dispensary level for ART scale up. The main **malaria** prevention and control interventions in the Region include rapid tests, ALU/ACT, ITNs and environmental sanitation measures, with Save the Children UK. No indoor residual spraying (IRS) is carried out. **TB and leprosy** case finding and DOTS treatment interventions are undertaken in collaboration with EGPAF and German Leprosy and TB Association (GLTBA). Only one (1) "recent" MDR/XDR case was referenced in Region, approximately three years ago (2010) and there are no social welfare or protection for leprosy patients in place. National guidelines for neglected tropical diseases (**NTDs)** prevention and management for hydroceles, filariasis, schistosomiasis and trachoma are available. NTD service delivery partnerships are in place with IMA WorldHealth, Hellen Keller International (HKI) and WHO mainly for mass drug administration (MDA) campaigns and associated technical support. For non-communicable diseases (**NCDs**), no major partner was referenced by any Lindi HF in-charges at any level. In effect, NCD services for diabetes and hypertension are only available at either the Lindi RRH OPD or at quarterly AMREF "flying doctor" clinics.

Lindi Region CHMTs visited most cited cholera, meningitis, plague, rabies and yellow fever as **notifiable diseases**. **Case management guidelines** were reportedly available from central MOHSW (not confirmed), with a request that Swahili versions, not just English, are needed especially at Health Center and Dispensary levels. Public health **legislation**, i.e. the Public Health Act and Environmental Management Act were reportedly available at Lindi RRH but no where else. The frequency of referencing these two legislative documents was not clear. Disease-specific case fatality rates (**CFR**s) were reported to be available at Lindi RRH and DHs. There were no standardized no standardized (EPR-related) clinical management approach for disease outbreaks, i.e. mainly for cholera (2011, 2007 outbreaks in urban areas). Chronic malnutrition was referenced by CHMTs in some areas with collaborative support with Save the Children UK.

One district hospital in-charge indicated that **integration of vertical disease programs** is sometimes difficult at hospital level as donors deal directly with MOHSW centrally and communication at lower levels is less than optimal. This is particularly the case with the different components of HIV/AIDS interventions: prevention, ART C & T, with evident "donor biases" for implementation of their component, militating against sensible integration of services at HF level.

## 10.2 Conclusion

There appears to be a level of MOHSW & PMO-RALG dependence on GHIs/international partners to plan, implement & monitor the large communicable disease programs for HIV/AIDS, malaria, TB/leprosy and NTDs. The full extent of this was not ascertainable during this field visit. Disease outbreak preparation (for cholera) is seen as synonymous to Emergency Preparedness & Response (EPR) rather than as a necessary but insufficient part of the latter. There appears to be scope for strengthening and folding in disease-specific CFR data into QIT agenda at RRH and DH levels. Opportunities also seem to exist for better integration of the large disease control programs from central MOHSW down HF levels to reduce the reported level of disjoined major programme delivery for Dispensary, Health Center, District Hospital and Regional Referral Hospital staff.

# 11. Emergency Preparedness

## 11.1 Findings

EPR guidelines from central MOHSW are reportedly referenced at Lindi RHMT level and used at District Hospitals with "emergency management teams" in place. However, both the Lindi RRH and Lindi Rural Designated District Hospital (DDH) had no active EPR team of any kind. Rather, both HFs reported dealing with cholera outbreaks as their main and central hazard as and when these presented. Similarly at CHMT levels, teams are reportedly in place, but meet only when a suspected/confirmed cholera outbreak occurs. EPR is budgeted in CCHPs mainly for drugs. CHMT EPR team members include DMO, DHO, DDO, Pharm Assistant & Lab Technician. Lindi Rural CHMT referred to a recent 5 day 2013 EPR training in Tanga but could not confirm EPR guidelines from MOHSW. Kilwa District Hospital reported having a Rapid Response Team, chaired by MO I/C. Its purpose is to address all emergencies, disaster events with a main focus on cholera and motor vehicle accidents.

## 11.2 Conclusions

In Lindi Region, there appears to be no coherent EPR program in place at health facilities , only ad hoc clinical response teams for cholera which are activated approximately once every 2-3 years. Standardized EPR policy and guidelines for use at HF levels need to be prepared and issued from MOHFW with a training program relevant to hazard profile and available staffing and technical skills at each HF level from Dispensary up to RRH.

# 12. Social Welfare and Social Protection

No SW Officers were available for inputs at any level during this visit to Lindi Region.

# 13. Monitoring Evaluation and Research

## 13.1 Findings

The new HMIS is being implemented in Lindi region (DHIS 2). Monthly reports from health facilities are checked and entered in the national database at Council level. This was said to take about 1 to 2 weeks. CHMTs have access to the web based HMIS.

Regional Health Management Teams discuss HMIS findings during their annual meetings with CHMTs. Infectious Disease Surveillance Reports are sent weekly to the Ministry of Health and Social Welfare.

HMIS is one of the agenda points during monthly CHMT meetings, and is also included as focal area during supervision to health facilities. One CHMT reported conducting quarterly HMIS meeting where data quality and use are being addressed. During supervision data is also sometimes entered directly in the system (staff take their laptops and modem along).

Challenges are late or incomplete reporting from health facilities (one Council reported 75% of reports being complete and on time). In addition, multiple (parallel) reporting systems for vertical programmes pose a strain on health workers. In addition to the DMIS 2 forms separate reports for e.g. EPI, Family Planning, Sexual Transmitted Infections, and Voluntary Counselling & Testing have to be produced. Some partners still ask for other specific reports. One CHMT reported that it was considering providing partners with access to the national web-based HMIS so that the amount of data items required by partners can be reduced.

Two reporting systems involving mobile technology are used: ILS Gateway and SMS for life. ILS Gateway monitors availability of 20 tracer items. Information is provided by health facilities using a coding system for items and SMS (mobile phones) for data transmission. Information can be accessed by the CHMT pharmacist using a web-based system. SMS for life reports on availability of malaria commodities.

For human resources information management two systems are being used in parallel, one from the Ministry of Health and Social Services and one from Prime Minister's Office – Regional and Local Government. Because these two systems are not linked their information might differ.

There is no research strategy at regional or council level. Teams participate in research initiated by government or partners.

## 13.2 Conclusion

Challenges of additional & sometime parallel reporting requirements remain (e.g. vertical programmes and partners). There is need for a strategy for harmonisation to reduce workload and to achieve an integrated routine HMIS. This should also include the mobile systems where there is some duplication in terms of items monitored including with the HMIS indicator medicines.

In terms of Monitoring and Evaluation there was no clear evidence that RHMTs and CHMTs try to establish links between reported achievements (activities implemented) and overall health sector results.

# 14. Other Issues: Capital Investments

## 14.1 Findings

At Lindi RRH, CHMTs and DHs visited, guidelines/plans for rehabilitation and repairs of physical plant (outside of what is in CCHPs) were non-existent. Despite severe disbursement cuts, capital investment was observed at District Hospital, Health Center and Dispensary levels with respect to new or renovated clinic buildings (e.g. renovated maternity ward), including some staff accommodation. Where infrastructure development was in evidence, three sources of funding were usually cited for capital investment: I) MMAM funds from central level; ii) Council and iii) community [labour, in kind].

Staff housing was reported at all HF levels as the most important area of capital investment need, especially at Health Center and Dispensary levels. The MTR team was also advised that Dispensaries were not designed for large consignments and issuing of pharmaceuticals (little space for this); this should be rectified in any future re-design plans for Dispensaries. Outside of physical plant, recurring reported water supply problems were reported at most HC & Dispensaries visited and somewhat less so for electricity supply.

## 14.2 Conclusion

It is unclear how the apparent level of observed capital investment at HF level is possible in Lindi Region when funding disbursement levels from Block Grant + Health Basket have been declining. Dispensaries should be designed in future for large consignments and issuing of pharmaceuticals (little space for this). Consideration may be given to a more flexible use of user fee funds for fixing local, immediate water supply issues at HFs.

# 15. Other Issues: Medicines and Supplies

## 15.1 Findings

Councils noted that the **budget** allocated to pharmaceutical commodities was too small to cover needs. Having the Health Basket Fund as an additional source was appreciated. Despite the reported shortfall in the pharmaceutical commodities budget earmarking of health basket and cost sharing funds for medicines procurement was not supported by all Councils.

CHMTs are informed when the central budget is made available at MSD and MSD provides quarterly health facility statements. Some health facilities reported that disbursement delays do not affect them, because MSD provides credit against the approved budget. This does not apply to hospitals, however.

Lindi is one of the regions where **MSD** has implemented the Direct Delivery System (DDS) (MSD delivers orders to each health facility). Except for one health centre that reported not having received any supplies for eight months, all facilities noted that the DDS is a big improvement for timely delivery of orders. Health Facility Governing Committees witness delivery of medicines. Communication with MSD zonal store in Mtwara is good. In general, MSD is seen positively, especially regarding communication and prices.

A mixed picture emerged in terms of **medicines availability**, which sometimes was noted as an achievement and constraint at the same facility. There are common complaints that MSD is not fully honouring orders in terms of quantities and type of items. For example, one Council reported having placed orders in the value of TZS 85 million and only received supplies valued TZS 20 million (2012/13) and the DDH reported usually receiving less than 50% (in terms of value) of what was ordered. Items that were found to be out of stock in health facilities on the day the team visited included ACTs, RDTs, co-trimoxazole, implants, measles vaccine, paediatric TB medicines, and prednisolone.

The procedures for procuring medicines that are out of stock at MSD from alternative suppliers was said to be complicated and slow, which is particularly relevant for pharmaceuticals, because they are needed urgently. However, the system is still being used (some think it is smooth). MSD now indicates missed items on the proforma invoice, which the health facility can use as proof of out-of-stock. In line with public procurement regulations Councils have pre-approved suppliers from whom to buy medicines. Not all of those are located within Lindi region and challenges include delays in delivery and high prices. At health facility level the Health Facility Governing Committee has to approve this type of procurement.

All health facilities visited had **expired medicines** but those were reported to have been there for a long time. The disposal procedure is very complicated. There were no specific complaints that MSD delivers short-dated medicines.

In all health facilities visited some staff members had been recently trained in **the Integrated Logistics System** (ILS). One CHMT reported that since then ordering had improved considerably but there were still some problems with correct completion of ILS forms. CHMTs use information on stock outs in the districts health facilities provided through the web-based ILS Gateway for redistribution.

Hospitals visited had received training for **Medicines Therapeutic Committees** (MTC) two years ago, and MTCs are established. However, meetings tend to be less frequent than envisaged. Standard Treatment Guidelines (including the National Essential Medicines List) are available at hospitals.

However, pharmacists reported that the MSD Catalogue is used as main reference for deciding on which items to order.

**Drug stores** are generally small and tend not to be well maintained. Exceptions are the areas where 'Continuous Treatment and Care' (CTC) items are stored. Some health facilities (including one big health centre) did not have a separate dispensary.

CHMTs are involved in supervision of Accredited Drug Dispensing Outlets (**ADDO**), as some of the CHMT members are also members of the Council Food & Drugs Committee. Two CHMTs reported that ADDOs were inspected regularly, one noted the unavailability of transport as reason that inspections were not done as needed. ADDOs frequently do not comply with the regulations (e.g. inadequate record keeping, sale of unauthorised medicines, sometimes MSD medicines are found). As a consequence 2 ADDOs were closed down in Lindi rural council.

## 15.2 Conclusion

Financial resources for pharmaceutical supplies remain limited, exacerbated by out of stock occurrences at MSD and lengthy procedures and high prices to procure from alternative suppliers. Capacity of health centre and dispensary staff to comply with the manual ILS remains inadequate, which can contribute to stock outs. ILS Gateway can facilitate increased availability of tracer medicines. The Ministry of Health and Social Welfare together with partners could assess whether there are options to either simplify the paper-based system or expand the mobile system (in term of items included).

Health facilities receive specific technical support/supervision for donor supported programme items (e.g. CTC); inventory management/storage of these items is clearly better than that of other essential medicines. There might be lessons learnt that could improve management of all essential medicines.

The issue of rational use of medicines is not addressed comprehensively. We assume that savings and improved quality of care could be achieved by capacity building in this area. MTCs currently focus on medicines availability and procedures for procuring medicines that are out of stock at MSD. Rational use of medicines is within the mandate of MTCs and their role in that regard could be strengthened.

ADDOs remain the only alternative in rural areas. However, capacity for control is low and quality of services not upheld. Aiming to increase the number of ADDOs without strengthening the related inspection and quality assurance systems will not improve access to quality pharmaceuticals.

# 16. Other Issues: ICT in Health

## 16.1 Findings

Computers are available at hospital level only but to a different degree. For some facilities availability is acceptable, while in others some key staff (e.g. HMIS officer) do not have dedicated desk tops and use their personal laptops. In many cases desktops were provided through vertical programmes and used primarily for that purpose.

Anti-virus protection is not comprehensively available (e.g. purchase of limited number of licenses used throughout facility or no provision at all).

Internet connection is available at CHMTs and hospitals but it was reported to be unreliable and slow, impacting the effective use of tools like EPICOR.

## 16.2 Conclusion

ICT development seems ad hoc and donor dependent. Mobile technology pilots are working (ILS, SMS for life) but the potential for expanding applicability is not clear.

# Annex 1: Lindi Team Members

| | |
|---|---|
| Sidney Ndeki | HSSP III MTR team member |
| Stephen R. Collens | HSSP III MTR team member |
| Marianne Schurmann | HSSP III MTR team member |
| Timah Twalipo | Embassy of Ireland |
| Nassoro B. Shemzigwa | Economist, Div. of Services Delivery, PMO-RALG |

# Annex 2: List of People Met

| S/N | Name | Position | Organisation | Location |
|---|---|---|---|---|
| 1 | DR. NICHOLAUS S. MMNUNI | Emergency prep.focal Person | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 2 | ZAINABU MARTRADAS | Regional Reproductive & Child Health | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 3 | ADOLFINA B. NJALAL | Maternal Health Care | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 4 | DR. EDGAR A. MLAWA | Ag. RACC | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 5 | HUSNA MAKAME | Ag. Regional Pharmacist | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 6 | DR. JOSEPH SHIBOLA | RDO | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 7 | TAWANI SELEMANI | Ag. RHS | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 8 | DR. ABDALH A. P. | Ag. RMO - Lindi | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 9 | JOHN LIKANGO | Ag. RAS | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 10 | DR. ALLEX D. HAMIS | Ag. MOH | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 11 | RITHA E. NAKUA | ASSIST HOSP MATRON | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 12 | PRISCA UNGA | HOSP. BOARD MEMBER | LISAWE | LINDI TOWN |
| 13 | MELANIA FELIX | HOSP. BOARD MEMBER | PEMOA | LINDI TOWN |
| 14 | COSMAS BULU | HOSP. BOARD MEMBER | LIWOPAC | LINDI TOWN |
| 15 | PROSPER NDIMBO | HOSP. BOARD MEMBER | LIDEP | LINDI TOWN |
| 16 | DENNIS J. MAHUNDU | HOSP. BOARD MEMBER | LIDEP | LINDI TOWN |
| 17 | THOMAS F. LIHAWI | HMT | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 18 | EDWIN S. NGONGOLO | HMT | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 19 | FATUMA KHATAU | HMT | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 20 | FELINUS F. MHASI | HMT | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 21 | DR. HAMIS AJAU | HMT | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 22 | KENETH KOMBA | HMT | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 23 | DAVIS MAGANGA | HMT | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 24 | BEATRICE M. LILAI | HMT | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 25 | MSAFIRI SEHABA | RNO | SOKOINE REG. HOSPITAL | LINDI TOWN |
| 26 | DR. GODIAN MTWANGAMBATE | MMO | LINDI MC | LINDI TOWN |
| 27 | ANDERSON D. MSUMBA | Ag. Municipal Director | LINDI MC | LINDI TOWN |
| 28 | NELSON IGNAS BENO | Chairperson SSC | LINDI MC | LINDI TOWN |
| 29 | KASIM LITONJI | Social Service Committee | LINDI MC | LINDI TOWN |
| 30 | ZAHARA S. HAMZA | Social Service Committee | LINDI MC | LINDI TOWN |
| 31 | MOHAMED LUHUMBO | Social Service Committee | LINDI MC | LINDI TOWN |
| 32 | DR. ALUTUPHINE DAMALU | DTLC Lindi (E) | LINDI MC | LINDI TOWN |
| 33 | ABILAHI R. MBINGU | MNO | LINDI MC | LINDI TOWN |
| 34 | DR. ENOUL CHILUMBA | HIV Control Co - ord | LINDI MC | LINDI TOWN |
| 35 | SEIF A. SEIF | DCCO | LINDI MC | LINDI TOWN |
| 36 | METHUSELA MAGAYANE | Ag. DSWO | LINDI MC | LINDI TOWN |
| 37 | STEPHEN HAJJI | NTDs Cord | LINDI MC | LINDI TOWN |
| 38 | FAIDA IBRAHIMU | DRCHCO | LINDI MC | LINDI TOWN |
| 39 | RAMADHANI MALUMRU | MHS | LINDI MC | LINDI TOWN |
| 40 | IMANI KOMBA | CHFCO | LINDI MC | LINDI TOWN |
| 41 | JUVENALI MAUM | MHO | LINDI MC | LINDI TOWN |

| S/N | Name | Position | Organisation | Location |
|---|---|---|---|---|
| 42 | SELEMANI S. NGAWEJE | Ag. DED | LINDI DC | LINDI TOWN |
| 43 | MONICA WEMA | Asst. DRCHCO | LINDI DC | LINDI TOWN |
| 44 | MOSI KIMBETULE | DNO | LINDI DC | LINDI TOWN |
| 45 | DR. KAZEMBE H. MKUNGA | CTC i/c | LINDI DC | LINDI TOWN |
| 46 | COSTANTINE MATIMO | DAMO | LINDI DC | LINDI TOWN |
| 47 | ELVAN J. LIMWAGU | Health Officer | LINDI DC | LINDI TOWN |
| 48 | REGINA KUNACHE | DHBC - Co | LINDI DC | LINDI TOWN |
| 49 | MFAUME HEMEDI | HMIS Coordinator | LINDI DC | LINDI TOWN |
| 50 | DR. BONIFACE RICHARD | Ag. DMO | LINDI DC | LINDI TOWN |
| 51 | DR. AJILI MILANZI | A.M.O | RUTAMBA HC | RUTAMBA |
| 52 | MWANAIDI KAMALIZA | E/NURSE | RUTAMBA HC | RUTAMBA |
| 53 | GERALD CHILEMBA | CLINICAL OFFICER | RUTAMBA HC | RUTAMBA |
| 54 | SAFINA MANZI | M.A | RUTAMBA HC | RUTAMBA |
| 55 | MAYASA MMAVUA | M.A | RUTAMBA HC | RUTAMBA |
| 56 | AMINA MBEGWA | N/A | RUTAMBA HC | RUTAMBA |
| 57 | AGNES KAPINGA | L/AS | RUTAMBA HC | RUTAMBA |
| 58 | THERESIA MALUCHILA | CO | MAHUMBIKA DISP | MAHUMBIKA |
| 59 | SOPHIA G. KUNACHE | M/ATTEND | MAHUMBIKA DISP | MAHUMBIKA |
| 60 | MATILDA PILILA | M/ATTEND | MAHUMBIKA DISP | MAHUMBIKA |
| 61 | FATUMA SHAKHARY | EN | MAHUMBIKA DISP | MAHUMBIKA |
| 62 | RUZZARD YANKIEVIZ | Head of Surgical Dept | NYANGAO HOSPITAL | NYANGAO |
| 63 | EDGAR CHILEMBA | PATRON | NYANGAO HOSPITAL | NYANGAO |
| 64 | SR. FAUSTA LIUNDI | Ag. DR. INCHARGE | NYANGAO HOSPITAL | NYANGAO |
| 65 | ANDREA MARKUS | PHARM TECH I/C | NYANGAO HOSPITAL | NYANGAO |
| 66 | DITRICK MWAMBE | MAINTANANCE OFFICER | NYANGAO HOSPITAL | NYANGAO |
| 67 | INNOCENT A. CHINGUILE | LABORATORY MANAGER | NYANGAO HOSPITAL | NYANGAO |
| 68 | EVARISTA S.MILANZI | ASST. SUPPL | NYANGAO HOSPITAL | NYANGAO |
| 69 | DR. STANSLAUS WAMBYAKALE | PAEDIATRICIAN | NYANGAO HOSPITAL | NYANGAO |
| 70 | DR. MAX MAKOTA | MOIC | NYANGAO HOSPITAL | NYANGAO |
| 71 | JOSEPH NJENGA | HUMAN RESOURCES OFC | NYANGAO HOSPITAL | NYANGAO |
| 72 | DR. NASSORO HAMID | HON. DC | LINDI | LINDI TOWN |
| 73 | EPIPHANIA MOSHA | DAS | LINDI | LINDI TOWN |
| 74 | ABDU SAID | CO - IN CHARGE | NACHINGWEA DISP | LINDI TOWN |
| 75 | MAGDALENA MBINGA | NA | NACHINGWEA DISP | LINDI TOWN |
| 76 | MUSTAFA FLORIAN | CO - IN CHARGE | TOWN HEALTH CENTER | LINDI TOWN |
| 77 | EDINA NANGALA | R/N | TOWN HEALTH CENTER | LINDI TOWN |
| 78 | CHRISTOWELU KITUNDU | E/NURSE | TOWN HEALTH CENTER | LINDI TOWN |
| 79 | RAYMOND A. NDUMBARO | Ag. DED | KILWA DC | KILWA DC |
| 80 | DR. MIKE MABIMBI | DMO | KILWA DC | KILWA DC |
| 81 | JOYCE E. MWAMBE | EN | MPARA DISP | MPARA |
| 82 | ILUMINATA MASAWE | SM/Attendant | MPARA DISP | MPARA |
| 83 | MWANAHARUSI OMARY | M/ATTEND | MPARA DISP | MPARA |
| 84 | NGOMA T. MBAGO | DHS | KINYONGA HOSP | KILWA KIVINJE |
| 85 | FRANSIS J. NDUNGURU | Radiographer I/C | KINYONGA HOSP | KILWA KIVINJE |
| 86 | OMARY M. MKETU | DLT | KINYONGA HOSP | KILWA KIVINJE |
| 87 | DANIEL MASSENGA | Hosp. Pharmacist | KINYONGA HOSP | KILWA KIVINJE |
| 88 | SOSTENES G. NJIKWA | DHO | KILWA DC | KILWA DC |

| S/N | Name | Position | Organisation | Location |
|---|---|---|---|---|
| 89 | DR. BERNARD MAGODA | DACC | KILWA DC | KILWA DC |
| 90 | WAZIRI MASHAKA | DPHARM | KILWA DC | KILWA DC |
| 91 | N. A. JEREMIAA | DIVO | KILWA DC | KILWA DC |
| 92 | JAFARI THOBISA | DTLC | KILWA DC | KILWA DC |
| 93 | ANNA P. KWEKA | HHO | KILWA DC | KILWA DC |
| 94 | JUMANNE SAIDI | Paediatric I/c | KINYONGA HOSP | KILWA KIVINJE |
| 95 | PETER SHIJA | HLT I/C | KINYONGA HOSP | KILWA KIVINJE |
| 96 | JUMA KHAMIS | theatre I/c | KINYONGA HOSP | KILWA KIVINJE |
| 97 | SOPHIA MKEMI | Maternal Health Care | KINYONGA HOSP | KILWA KIVINJE |
| 98 | DR. DOMINICK KITEGO | MOIC | KINYONGA HOSP | KILWA KIVINJE |
| 99 | MWANAISHA AMRANY | R/N | TINGI HEALTH CENTER | TINGI |
| 100 | AMINA KAWINGU | M/ATTEND | TINGI HEALTH CENTER | TINGI |
| 101 | SOMOE MAUNDU | M/ATTEND | TINGI HEALTH CENTER | TINGI |
| 102 | PILI MREMBO'S | M/ATTEND | TINGI HEALTH CENTER | TINGI |
| 103 | ALLY KUELEKETWA | M/ATTEND | TINGI HEALTH CENTER | TINGI |
| 104 | NURUDINI MKINA | M/ATTEND | TINGI HEALTH CENTER | TINGI |
| 105 | PAULO SANGA | M/ATTEND | TINGI HEALTH CENTER | TINGI |
| 106 | HABIBU MAGINA | H/A | TINGI HEALTH CENTER | TINGI |
| 107 | HASHIMU N. MWINGILA | SECURITY GUARD | TINGI HEALTH CENTER | TINGI |
| 108 | DR. BETRAM MNYANI | PRINCIPAL | COTC LINDI | LINDI TOWN |
| 109 | DR. PAUL NYEHO | TUTOR | COTC LINDI | LINDI TOWN |