United Republic of Tanzania
Ministry of Health and Social Welfare

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

Geita Region Field Visit

October 2013

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Recommended Citation: MOHSW. 2013, Mid Term Review of the Health Sector Strategic Plan III 2009 – 2015, Geita Region Field Visit, Field Report, Ministry of Health and Social Welfare, United Republic of Tanzania

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Contents

List of Tables

1. Geita Region Profile

Geita region is a newly formed region lying to the extreme northern part of Tanzania divided from Mwanza, Kagera and Shinyanga regions. The region is bordered by Lake Victoria, especially in the north and east parts. Administratively the region has five districts and one town council, Geita district, Chato district, Bukombe district, Nyang'wale and Mbogwe districts and Geita town council respectively. The region has 18 divisions 98 wards, 540 villages and 2016 hamlets.

Table 1: Size of Population and Number of Villages and Wards

Name of Council	Population size	Number of wards	Number of villages
GEITA DC and TC	807,619	35	212
CHATO DC	365,127	22	128
BUKOMBE DC	224,542	13	122
MBOGWE DC	193,922	16	67
NYANG'HWALE DC	148,320	12	54
REGIONAL TOTAL	1,739,530	98	583

Source: NBS 2012

Geita has a population of 1,739,530, of whom 861,055 are male and 878475 are female as per the 2012 census.

The region's rural population is relatively poor and conditions are worsening due to high population density and consequent land shortage, exacerbated by erratic rainfall patterns in many parts of the region. Geita Region is dominated by small-scale farmers, miners, and fisheries. Agriculture employs about 80 per cent of the region's population and is complemented by an expanding mining, fishing and livestock keeping activities. Commercial fishing is carried out by small scale fishermen using primitive fishing gears and vessels. The region holds a large proportion of the country's livestock especially in Nyang'hwale and Bukombe districts.

Geita TC, Mbogwe and Nyang'wale are newly formed councils, thus do not yet have consolidated statistical records. Based on HMIS data available for the three districts with consolidated data in 2012, a summary regional health profile is provided below.

Table 2: Selected Health Indicators for Geita Region

Infant mortality rate per 1,000 live births(< 1year)*MDG 2015:38*	**22.3**
Under five mortality rate per 1,000 live births *MDG 2015: 64*	90
Underweight children under-five years of age (%) *HSSP 2015: 2%*	0.86
Maternal mortality rate per 100,000 live births *HSSP 2015: 265*	47.3
Birth at health facilities (%)	60.7
Births attended by skilled attendants (%) *HSSP 2015: 80%*	60.7
Contraceptive prevalence (%)	7.6
HIV prevalence among VCT clients (%)	6.3
Tuberculosis treatment success rate (%) *HSSP 2015: 82%*	93

Source: HMIS

2. District Health Services

2.1 Geographical Access to Health Care

In each of the districts visited, the MRT Team noted that there were not sufficient health facilities to cater for the population. The newly formed Geita Town Council does not yet have a hospital, referring patients instead to Geita District Hospital.

While some districts have managed to build new dispensaries through MMAM, planning for new facilities is constrained by the need, under the MMAM policy, for communities to initiative buildings and the inability to equip new facilities with adequate staff and supplies. In Chato district, which has been quite successful in planning under MMAM, completing two new health centres and 6 dispensaries since 2009, currently building one health centre and two dispensaries and planning for three more dispensaries by 2015, access to adequate facilities is still an issue – there are 128 villages but only 27 operational health facilities (all levels). In the region, the number of new facilities is not increasing at a rate that will ensure the achievement of the MMAM goal of one dispensary in each village.

Due to inadequate human resources for health, irregular drugs availability, state of disrepair of the facilities, the effectiveness coverage i.e. the number of people who receive a satisfactory service is low.

2.1.1 Management of Health Facilities

Village and Ward Development Committees are active in villages and wards. Availability and functioning of Health Facility Governing Committees (HFGC) varies. In some districts the CHMT reported that HFGC existed and functioned for the majority of health facilities; in others, maintaining HFGCs has been a challenge. Health Facility Management Committees appear to be functioning. In Geita TC, the CHMT invites members of the HFGC to witness the arrival of drugs to the district.

Traditional medicine is very rife in Geita region and, for many patients, the first point of contact is a traditional healer. For the vulnerable groups such as the elderly, the prevalence of traditional healers is a concern. The killing of old people on suspicion of being witches has been a common practice in this region and seems to be facilitated by traditional healers instilling into the perpetrators' minds the notion that old people and especially women are the cause of sickness and deaths in the community. The majority of the elderly who are killed are female. The regional and district administration has instituted measures to stop this harmful traditional practice.

Outreach services that were in operation in some of the health facilities were terminated due to inadequacy of funds.

Many of the health facilities in the region are in a bad state of repair and require rehabilitation works. Electricity availability is an issue in the districts, with many facilities operating from solar power. Running water is not available in the majority of health centres and dispensaries - instead rainwater is harvested. Sanitary conditions are not satisfactory.

Supply of medicine: Facilities face challenges of stock outs on a regular basis, including of tracer drugs, attributed to the lack of availability of drugs through MSD. Councils reported partially filled orders from MSD on a regular basis and that patients were sometimes requested to purchase/bring their own gloves, sutures, delivery kits, bed sheets etc. From 2013/14, MSD will begin directly delivering to the health facility level.

Human resources for health is a challenge in the region, with only 49% of positions filled. Staff in place is evenly divided between skilled professionals and non-professionals. Maintaining staff morale is also a challenge due to the frustrations of working with inadequate equipment and supplies.

2.1.2 Total Quality Improvement Framework

Districts have instituted Total Quality Improvement Committees in the hospitals that meet weekly to assess quality of care in all the units in the hospital. At lower level facilities, these committees do not yet exist. In Chato District Hospital the committee developed the mission, vision and values of the hospital. The team developed an organogram where every staff member knows to whom she or he reports and every staff knows his/her supervisor. The system of accreditation that has already been initiated at MOHSW has not reached the Regional and District levels.

The team has been trained on quality assurance. External quality control of laboratory services is done by the National Health Laboratory. Even though the committees are functioning, due to inadequacy of equipment, medicines, supplies and staffing (also skill mix), quality may still be compromised.

Guidelines: The majority of guidelines, standards and protocols were available at council level. A list of various guidelines that were available during the review is attached in the appendix. Staff indicated that as their training was in English they still prefer and understand guidelines that are in English.

2.1.3 Essential Health Package

Health facilities provide the Essential Health Package. There is adequate integration of services especially the RCHS and HIV testing (The PMTCT services in the ANC; the PICT in the OPD; TB and HIV and AIDS services). VTC appears to operate as a parallel service with infrastructure and equipment of higher quality.

2.2 Management of Health Care

Councils did not appear to have Council Health Strategic Plans in place, however, councils did appear to have some activities, especially infrastructure related, planned until 2015. Council Health Services Boards were functional and have also been established in the newly formed districts. Ward development committees (WDC) exist in both the new and old councils; however, there is a varying degree of functionality of the WDC.

CHMTs were unclear on how they prioritise the activities in their CCHPs, implying that councils are still struggling with priority setting of activities to take up into the CCHP. The CCHP guidelines give criteria to be considered in prioritizing activities but are silent on how to operationalise them simultaneously. This calls for capacity building in priority setting mechanisms that consider all criteria at the same time (i.e. the trade-offs). However, it was evident that councils are prioritising core activities within their available budget from health block grant and health basket fund.

Councils appeared to follow the procedures for planning: hosting a pre-planning meeting for private sector, FBO and NGO involvement and receiving plans from hospitals, health centres and facilities. However, health centres and hospitals reported that many of the activities within their plan are not included in the CCHP and they are not involved in the decision-making process, nor do they receive feedback on the process.

Adherence to budgets is a challenge as funds are delayed or not released in full. This is a challenge across all sources of funding to the council.

All councils have members trained on Plan Rep, although Geita TC reported that only the DMO has received full training and other members are self-taught with assistance from the DMO. Despite attending training in planning, transfers of already trained CHMT member often affect the planning knowledge base of the CHMT. None of the members are trained with EPICOR – this is managed by the district council.

Supportive supervision was in place in all districts. As Geita is a new region, the RMHT had yet to commence full supportive supervision to the districts. However, districts reported that their "mother regions" had provided quarterly supportive supervision as required in the previous financial year and found supportive supervision to be very beneficial. CHMTs are providing supportive supervision of between 2-3 hours a month to all health facilities but face challenges in implementing this activity due to shortage of funds for fuel, insufficient availability of vehicles, competing priorities at district level and time constraints. In the newly formed Geita TC, only one vehicle is available for the whole council (not just health) to complete such activities.

3. Referral Hospital Services

District and Regional hospitals: There is no regional hospital in Geita as of yet, however, plans are underway to build a new regional hospital. Patients requiring specialised care are referred to Bugando MC.

Capacity to handle referrals is poor in the health facilities and ambulances for transfer of patients are few. The community, therefore, has limited access to specialised referral services. In Bukombe District only the hospital and one of the three health centres has an ambulance. In Chato District, the CHMT provides each facility with phone credit vouchers to enable them to communicate the need for an ambulance or referral. In Geita TC as well as Bukombe district health facility staff must use their own credit to contact an ambulance in emergency situations.

4. Central Level Support

4.1 MOHSW and Agencies

In each district, roles and responsibilities of the various stakeholders in health were relatively clear, and all were supportive of the decentralisation process. The RHMT and CHMTs were supportive of the role of the RHMT in linking districts to central and are not be supportive of reporting directly to central level.

As noted earlier, the practice of traditional medicine is widespread in the region. Traditional Healers are required to be registered with the District Executive Director (DED) but are not institutionalised into the health system.

4.2 Regional Level

The RHMT is newly established and as of now, many of the members are in acting positions, are new to the position and are still learning about responsibilities and reporting lines. 2012/13 is the first year for the RHMT to have a plan and budget and the first year to be providing supportive supervision to the districts. Some members of the RHMT received training on supportive supervision, including toolkits, and reporting in 2012. However, few members of RHMTs or CHMTs have been trained in mentorship skills.

Due to funds for 2013/14 not yet being available at the regional level, the RHMT has commenced supportive supervision through piggybacking on activities of the Water and Sanitation Team. This has allowed the RHMT access to a transport.

5. Human Resources for Health

Human resources for health is a considerable challenge for the region. Less than half of all staff positions are filled, and half of these are non-professionals. Many of the members of the CHMT and RHMT are in acting positions and there are a number of vacancies on the RHMT and the new Chato TC.

Districts appear knowledgeable about human resource policies and changes to policies/new policies are shared with the districts through circulars and to staff during meetings and supportive supervision. However, in many districts, there is no dedicated HR planning and management focal person.

The use of bond, retention and incentive schemes at district level are limited. Some districts are providing staff housing as an incentive, however there is not sufficient housing for the numbers of staff. It is a challenge for districts to retain new employees; a small percentage do not report to the district and approximately 80-85% of those who report, remain past one year. It is particularly difficult to retain female staff as they leave to marry and follow their husbands.

The shortage of staff at regional and district levels has led to many CHMT and RHMT members, and staff members at facility levels, occupying multiple positions e.g. the RCH Officer is also Ag. Nursing Officer. As a result, staff is over-burdened and obliged to work overtime, for which they are paid. This is an inefficient short-term remedy for a chronic situation. There is also a misappropriation of skills within the region, e.g. the DMO in Geita TC is a surgeon but is unable to practice his profession due to administrative duties. Staff morale is also low as they are required to provide services without sufficient and quality staff, supplies and equipment.

HRHIS systems are in place in some districts but not all and availability of accurate HR information is limited. Geita TC specified that the HRHIS data for the council was not reliable. Effective utilisation of HRHIS is hampered by poor connectivity of networks and lack of internet. Human Resource Plans that determine and forecast requirements are not comprehensive and tend to lack information on the private sector.

The districts are using OPRAS but do not see any benefit from it. OPRAS forms are not being reviewed and there are limited to no incentives or motivation for improved performance. Rewards or sanctions related to OPRAS are not implemented.

Training/capacity building is predominantly through on the job training. International NGOs active in the region also provide training. In Bukombe district, the DMO was at a training workshop in Shinyanga (mother region) provided by ICAP during the field visit. Districts are severely limited in the ability to up-skill their staff due to the ban, prescribed by the Parliamentary Social Welfare Committee, on utilisation of health basket funds for training. This was originally put in place for two years but now appears to have been carried forward into its third year.

6. Health Care Financing

At council level, the major sources of funding are Health Block Grant and Health Basket Fund, supplemented by vertical programmes, cost sharing and council own sources. User fees account for a very small proportion of the budget and council own sources funds is very limited in most councils. None of the councils have thought of any financing strategy to address the financing gaps.

There is concern over the delays in and levels of disbursement at council level. Health Basket Funds are regularly delayed and one district reported receiving the 2nd, 3rd and 4th quarter funds in the final quarter. However, the full allocated and budget amount is received. The health block grant, in addition to always being delayed, is often short of the approved/budgeted amount, particularly the OC portion.

Some districts are familiar with the resource allocation formulae but are concerned that the formula for health block grant does not take into consideration the number of staff within the district. In Bukome District, the number of staff has increased significantly but the OC allocation has not.

Generating resources through complementary financing in the region has not been very successful. In Bukome region, CHF enrolment increased significantly but this was due to a group scheme enrolment. In Geita District (not TC), Plan International and ELCT were operating a group scheme but this ended in 2012. Beneficiaries did not renew their membership. Enrolment in CHF/TIKA is low due to lack of drugs in facilities, lack of skilled staff, unattractive benefit packages, local beliefs (preference for traditional healers), etc. Delay in receiving the NHIF card was cited as another challenge. Councils are also concerned with the matching funds conditions under the NHIF system.

Plans to increase CHF/NHIF enrolment include sensitisation and advocacy campaigns. The District Commissioner in Chato plans to visit each ward/village where he will discuss the CHF amongst other issues. In Geita DC, the CHF focal point said there is insufficient funding to sensitise the community to benefits of CHF but that Village Health Executive Committees had the task of promoting CHF within the community. Geita DC also plans to adopt the NHIF model of accrediting private pharmacies for CHF member to access missing medicines and drugs from the health facilities.

All councils visited have exemptions and waiver system in place. However, councils have heard reports from patients that they have been requested to pay fees despite qualifying for exemptions. It is difficult for the councils to implement the policy due to the critical shortage of staff, medicines and equipment. Some councils highlighted that pregnant women have been asked to purchase delivery kits, including water and kerosene for use at the facilities as supplies from MSD are not forthcoming. Chato DC has given an identity card to the elderly to enable them to access free medical services. The challenge in all councils is that there is no systematic approach in identifying vulnerable populations. - most councils rely on the social welfare officers.

Data on proportions of poor enrolled in insurance schemes are not readily available.

To ensure efficient collection of user fees, the councils have a centralised collection system at hospital level. The centralised collection system has boosted revenue generation through user fees by reducing leakages. At the health centre and dispensary level, leakages are still reported.

Councils have consolidated all revenue accounts for efficient management and all of them are using EPICOR accounting software to manage funds. However, the use of a consolidated accounting system has brought challenges in accessing cost sharing money. Health facilities complained of the duration it takes to access the cost sharing money due to bureaucratic procedures with the council financial

management system. Health centres would prefer to operate their own bank accounts to facilitate ease of access to complementary funds.

Councils also highlighted that the long procurement system does not allow savings of resources for other activities as it is always expensive to buy through tendering as compared to market prices.

Most of the councils have planned and budgeted for performance based financing (i.e. pay for performance) in the CCHP as required, using cost-sharing or council own source funding. However, in reality, due to shortage of funding, health facilities are not rewarded, despite succeeding in reaching targets. This could have an impact on morale of staff. In Bukombe District, the CHMT rewards facilities who provide their reports on time using OC funding. Staff members from facilities are expected to deliver their reports on time from facility to CHMT without being provided with transport or costs. The reward covers the transport costs and encourages timely delivery of reports.

All the visited councils are audited by NAO and use PlanRep tool during planning and budgeting. However it is not clear to what extent the findings of these audits are acted on or used to inform future planning and budgeting.

7. Public Private Partnership

Districts have included in the CCHPs activities that will facilitate operationalisation of PPP. PPP committees are functional at CHMT level bringing together government, private for-profits and private not-for-profits to facilitate collaboration. The committees meet every 6 months.

Chato and Bukombe Districts have signed service agreements with TANSECO to treat their staff.

Various insurance schemes (NSSF, Strategy etc.) cover patients treatment fees but there has not been service agreements signed with FBOs or the for profit partners.

8. Maternal Newborn and Child Health

The RHMT is the structure within the LGA that is responsible for the management of health services at regional level. It supports the district health teams in the planning, management and supervision of district health services. Maternal New-born and Child Health (MNCH) as well as other reproductive health (RH) services are under the Regional Reproductive and Child health Coordinator (RCHCO), at regional level and at the district level it is the District Reproductive and Child Health coordinator

The MoHSW has developed the National Road Map Strategic Plan Strategic Plan To Accelerate Reduction of Maternal New-born and Child Health Deaths in Tanzania (2008-2015), also referred to as the" One Plan". The One plan aims:

- To ensure improved coordination of interventions and delivery of services across the continuum of care
- To guide implementation across operational levels of the system so that policy drawn at national level will be carried out at district and community level with support from the region, and the overall goal of the National strategic Plan is to accelerate the reduction of maternal new-born and child mortality and morbidity, and the attainment of the MDG4and 5 in Tanzania.

Geita is a new region and Geita urban is a newly established district, and has no district hospital. The RHMT is in the process of being reconstituted and it is still incomplete. The RMO has not yet been appointed and we met Mr Lupangisha who is the Regional Health Officer and also the Acting RMO. The RHMT has been trained on supportive supervision of the CHMT and generally they have a general understanding of their role, even though they have not yet initiated activities as no budget was available for them during the past year, they expect to start implementing the RHMT plan for 2013/2014. However – they were not familiar with HSSP 111, as well as with the One Plan- the Road Map Strategic Plan for the Acceleration of the Reduction of Maternal New-born and Child Mortality, and in addition RRCHO was in acting position.

MNCH is prioritized and included in the regional health plan and the Comprehensive Council Health Plans (CCHO). We were however told that the basis of prioritization is because of the MOHSW guidelines that the CCHP must include items.

8.1 Access to MNCH service

All facilities offer a full range from district to dispensary level provide a full range of MNC services, including antenatal care, delivery care, postnatal care, PMCTC, under-five immunization, and family planning. However, the CHMTs at all the visited districts indicated that the number of facilities was inadequate, and thus there are several villages without a health facility, and this impact on access to care. Outreach and mobile services are undertaken at facility level to bring the services closer to the people – but some facilities had to cease doing so due to unavailability of transport- for example Kasamwa Centre in Geita

Antenatal attendance at least once is high, however, similar to other regions there is late booking and few women make the recommended four visits. At the facilities visited the provision of quality ANC was hampered by shortage of skilled staff and by frequent shortage of equipment's, supplies and medicines. Reported shortages included –HIV test kits, SP for IPT (facilities reported that they have not received any SP for more than four months), iron and folic acid, Hemoglobinometer and BP machines, and DBS

for infant HIV diagnosis. For example at Bukombe district hospital, there was only one working BP machine to cater for the whole hospital. The

The vaccination coverage for under-fives is also high. The DVO reported challenges with regards to the cold chain, in that when lower facilities run out of gas, transport is not always available to distribute the gas. There have been instances of the fridges shutting down and the facility in-charge had to transfer the vaccines to the district for storage. Some of the districts reported shortage of vaccines including BCG, and the new vaccines (the Rotor virus vaccine and PCV13) are not regularly supplied and inadequate supply and shortage of syringes.

Overall, facility delivery is low, and differs among the districts. In year 2012 facility delivery was 65% in Chato district, 33% in Geita district and 39% in Bukombe district. One of the main reasons given for home deliveries are; the long distance to the health facilities, lack of transport and the perceived quality of care, unavailability of skilled staff and the chronic shortage of basic supplies and medicines for a normal delivery (see below for details). The lower level facilities do not provide all the components of Basic Emergency Obstetric care (BEmOC). The main reason is that some of the staff had had no training on BEmOC; also facilities lack equipment such as Vacuum extractor and MVA kits. (At Kasamwa HC none of the staff had had training on FANC or BEmOC)

In all the facilities visited (including health centre and district hospital), the labour ward was run down and in need of repair. The delivery beds lacked proper mattresses and covers, and there was no running water; an example of this is Bukombe hospital and Bangwa health center. The staff reported a chronic shortage of gloves, syringes, oxytocin, cotton wool, disinfectants, mackintosh, infant weighing scale (Kasamwa HC) etc. other equipment's supplied e.g. forceps and scissors were reported to be of low quality and easily rusts and breaks. Misoprostol was available only at the district hospital. In an effort to overcome the chronic shortage of basic supplies, the staffs ask the women to buy and bring to the facility when they attend for delivery.

Another challenge is the lack of a reliable source of light, whereby facilities rely on kerosene lamps and also face inadequate supply of kerosene. In some facilities, the women are also asked to bring a bucket of water and kerosene.

In Bukombe, and Chato district only the district hospital provides Comprehensive Emergency obstetric care (CEmOC), however there are plans to upgrade one of the health centres (Bangwa) to provide CEmOC. Availability of transport for referral is limited as the district hospital has only one (Bukombe) or two ambulances (Chato). In Chatto, the facilities are provided with a cell phone and airtime to facilitate communication in case of emergency while this is not the case in Bukombe district.

Maternal mortality is high in the region and is acknowledged as a priority health problem and prioritized in the regional and district health plans. The main reported causes of maternal deaths are haemorrhage (PPH) a ruptured uterus, and sepsis. Blood transfusion is not readily available from the zone transfusion centre. The CHMTs highlighted that although the districts make effort to collect blood and send to the zone centre in Mwanza for screening and storage, they receive back less than one third of the amount sent to the zonal center. A recommendation by the CHMT is to establish a sub zonal blood transfusion center since the zonal one is too far- and to be able to save live in obstetric haemorrhage blood need to be more readily available.

Other health issues included high under-five mortality above the national average at 90 per 1000 birth. Malaria and pneumonia, and? HIV are reported to be important causes of both infant and child mortality. This was of concern to both the CHMT and the HMT we discussed with as they informed us of the inadequate supply and lack of antimalarial drugs including ALU and quinine as well as medicine for neonatal HIV prophylaxis.

Postnatal care is provided at facilities but the coverage is very low. Family planning acceptance is also low and differs from district to district. The reported estimate for the region was 14% in 2012, and the community is reported to have a preference for a large number of children. However in some district (Bukombe) there has been a dramatic improvement from 3% in 2009 to 23% in 2012). This has been attributed to community initiatives and outreach FP services with the support of Engender health.

8.2 Strengthening Health System to Provide Quality MNCH and Nutrition Services

This is key strategy in the one plan, and it includes among others; capacity development, strengthening the referral system, and research, monitoring and evaluation.

The MoHSW have developed several guidelines standards and protocols, for antenatal care, BEmOC, FP, PAC, IMCI etc. Our visits showed that only some of the guide's e.g. FANC was available at district level, and none at the lower facilities. There was an acute shortage of antenatal card (RCH-4) and under-five growth monitoring cards (RCH-1) at all facilities including the district hospital. At the district hospital they have separate partograph printed for monitoring labour. However at the facility level they normally use the partograph printed on the RCH-4 card so the lack of RCH-4 also translates to lack partograph for monitoring labour at the facilities. The staff improvised for the shortage by asking the Mothers to buy exercise books which they use as ANC cards and for recording immunization to the babies.

8.3 Community MNC

Where transport is availed, and the staff is adequate, they conduct mobile and outreach MNC services, where they provide ANC, FP, vaccination, and health education. In this activity the village leadership and the Community health workers (CHW) collaborate to mobilize the community. In both districts visited we were informed they have a close collaboration with the CHW as well as TBAs. In this regard The CHW and TBAs helps with data collection at community level from maternal and neonatal deaths, and they also motivate the women for facility delivery. There are plans to build a maternity waiting home at Chato district

8.4 Maternal Death Reviews

In both districts we were informed that every maternal death that occurs at the facility is reviewed within five days as required by the MOHSW. The HMT under the supervision of a CHMT member (usually DMO and DRCHCO) - undertakes the review with an objective to identify the cause of death and whether or not it was preventable. In Chato the Medical officer in-charge informed us that they have a system of taking action in case of negligence by the health provider as well as following up to provide feedback to the community in the form of education whenever it is determined that the delay occurred at community/family level

8.5 Total Quality of Care Framework

The hospitals and facilities visited implement the TQIF in that they have established quality improvement committees, and at least at the hospital they meet weekly. However the shortage of skilled staff, and infrastructure (run down facilities especially the labour wards), chronic shortage of equipment and basic supplies impact on the provision of quality care

9. Prevention and Control of Communicable and Non-Communicable Diseases

CHMTs had knowledge of the Public Health Bill (2009) and the Environmental Management Act. Chato DC inaugurated a three years sanitation campaign in which the Public Health Act will be used as a guiding tool in legal issues concerning the environment.

The district hospitals and CHMTs have staff in charge of disease surveillance The weekly reporting on Form 3B form diseases and new cases of infectious diseases and deaths report on 22 diseases(polio, anthrax, blood diarrhoea, cholera, meningitis, human influenza, diarrhoea in less than 5 years old, human influenza, kerato conjunctivitis, malaria, measles, neonatal tetanus, onchocercarciasis, plague, pneumonia in less than 5years, rabies/animal bites, smallpox, tick born fever, trachoma, trypanomiasis, typhoid, viral hepatitis and yellow fever).

The HMIS reporting systems has tools that facilitate disease surveillance: OPD register number 5 for the OPD, register number 2 for reporting health facility data and register number 19 for reporting quarterly and annually. However, a significant challenge is that OPD register is not always filled, especially when a clinician is not available.

As the OPD register is not always filled completely, it is not possible to accurately review the occurrence and incidence of diseases. Diagnostic support, which is not always available, is also necessary for accurate M&E.

Integrated reporting is done through MTUHA and IDS (Intergraded Disease Surveillance). Book 5 of MTUHA that reports OPD cases can be used for active surveillance. Active search for the occurrence of specific diseases can show its incidence. The weekly reporting of occurrence of diseases in the IDWE form integrates reports of occurrence of 22 diseases.

District Hospitals are equipped to do radiology, ultrasound and microscopy; however equipment is not always of high quality or functioning as noted elsewhere. Hospitals are also able to do the following laboratory tests: Haemoglobin, biochemistry, blood sugar, urine dips, Malaria Rapid Diagnostic test (MRDT). The District hospitals often run short of reagents for blood grouping and uni-gold for confirming HIV positivity. Reagents for hepatitis are not stocked in the districts. There is frequent shortage of HIV testing kits and demand for PMTCT, CTC, PICT and VCT cannot be met. Some of the shortfall is met by international NGOs operating in the council such as ICAP.

In all councils visited, staff had benefitted from capacity building activities for case management, including through training on malaria and IMCI.

Apart from home visits in villages that have Community Change agents (CCA) there are no notable community based treatment and care. In Bukombe district People Living With HIV/AIDS have directly benefited from a programme that provides Home Based Care (HBC) services and economic support to chronically ill patients (50% of whom are HIV positive) and provides support and protection of Most Vulnerable Children (MVC).

The infant mortality rate and child mortality rate are high in the region. The high child mortality is partially accounted for by the high malaria incidence and prevalence. Malaria is the number one reason for attending health facilities and the number one cause of child deaths.

Malaria: Universal access to malaria interventions includes advocacy, Indoor Residual Spraying (IRS), prophylaxis in ANC (in many districts, the SP for IPT has not been available for above 6 months) and provision of impregnated bed nets and the voucher system. Residual spraying has been done once a year since 2010 by the health department. Geita TC has partnered with Geita Gold Mines (GGM) to provide IRS. In urban areas residents care about privacy and IRS is not well accepted. Geita C has included larviciding as an alternative to IRS in the town.

The ITN voucher system has worked very well till May this year.

Capacity building in malaria diagnosis (MRDT-Malaria Rapid Diagnostic Test) was done in 2012. However, as there are stock outs on the reagents, this knowledge cannot be utilised.

Advocacy campaigns are taking place in the villages to explain the signs and symptoms of malaria and the importance of early diagnosis and treatment. Two out of the seven wards in Geita TC have been covered resulting in early attendance of children in health facilities.

HIV AND AIDS: The number of individuals tested for HIV has been increasing year by year. The various HIV strategies include VCT, Provider Initiative Counselling and Testing (PICT), PMYCT, Early Infant Diagnosis, Home Based Care (HBC), cotrimaxozole prophylaxis male circumcision and the ART programme. PICT has contributed towards increased testing for HIV infection. All health facilities in the councils visited offer PICT services. Records in ANC clinic and the labour ward show increasing numbers of women being provided with PMTCT services. All HIV infected patients with CD4 less than 350 are provided with cotrimaxosole prophylaxis. PEP is provided as per the guideline. Male circumcision is well accepted and is being done in static and mobile clinics. In Bukombe District, the ART programme started in 2006, starting from one centre to 8 centres in 2013.

TB and HIV services are integrated: every HIV infected individual is investigated for TB and every TB infected individual is investigated for HIV infection and treated according to the TB and HIV infection guideline.

The councils reported frequent occurrence of stock out of first-line ART. As a result, patients are often started on second line without first meeting the proper criteria.

Staff members are aware of the PEP regime and hospitals have the PEP Guidelines.

The Community Participatory Development Association in Chato district improved advocacy in malaria and HIV and AIDS Community Change Agents (CCAs) are involved in the community malaria initiative. CCAs follow up TB patients who are on therapy.

CHMTs reported that STI management is done according to the STI management guidelines. Drugs are available for treating via the syndromic approach, treating ulcers and PID. Easy accessibilityof condoms has increased uptake of the male condom. From our observations, YFS are not available.

FBOs, NGOs and the community have been involved in DOTS (Directly Observed Therapy) and staff have attended MDR/XDR-T management course organised by Kibongoto hospital. Councils send AFB positive sputum to the central laboratory at Muhimbili National Hospital and on examination if found to have multi drug resistant (MDR/xDR) the patient is referred to Kibongoto TB hospital.

Leprosy rehabilitation is not provided in any council in the region. Instead, patients are referred to Kolandoto hospital in Shinyanga region.

District hospitals send blood for screening to the Mwanza Zonal Blood Bank and receive weekly supply of screened blood. However, councils complained that less blood is returned to the hospital than they have sent. It was recommended by CHMTs that districts that have many maternal deaths like those in Geita Region be allowed to establish their own blood banks and be provided with Hepatitis B screening services.

NTD: Examination of urine samples for schistosomiasis has shown high infection rates of even up to 100%. Mass treatment has been done in the schools.

NCD: Capacity building of health workers on non-communicable diseases was provided by the Zonal hospital. District hospitals run Diabetes and Hypertension clinics and there is good availability of diabetes and hypertension drugs. There is a psychiatric nurse in charge of mental illness in the district hospitals and throughout the council. There appears to be no advocacy within the councils on lifestyle diseases.

In Bukombe DC, health centres and dispensary clinical staff were provided with training in management of patients with mental illness. Patients with minor mental illness can be treated in dispensaries and health centres and those with major illness like schizophrenia are referred and on diagnosis are followed up in the dispensaries and health centres. The problems in mental health include patient default as they come from long distances, from all over the district to get treatment at the district hospital and there are no patient supportive mechanisms installed at community level. CCHPs have included mobile mental health clinics as an activity but as funds are inadequate; these activities are not implemented fully.

10. Emergency Preparedness

There are no Disaster Response Teams and Emergency Management Teams at RHMT level or CHMT level in Geita Region. The Rapid Preparedness Committee is also absent in the hospitals. Thus, Systems at district and region for emergency preparedness and immediate emergency response are not established in this new region nor have there been any capacity building activities to enable the RHMT and CHMT to establish and effectively run the systems. Protocols and guidelines for emergency preparedness were not available.

Despite the absence of the necessary structures to initiate response to disasters, materials and drugs needed for rapid response are included in the CCHP e.g. for procuring drugs and drips in cholera epidemics. The CCHPs also include as activities detection of vulnerable communities for emergencies and response to emergencies by having in stock medicines and supplies needed. However, as articulated elsewhere, not all activities are implemented due to lack of funding and shortage/stock outs of drugs are frequent challenges.

There have not been any emergencies in this region this year but in May 2013, in Chato District, there was a measles outbreak involving 57 cases of unvaccinated children of nomadic pastoralist communities who had moved to the region from Kigoma region. During April/May 2012 there was an outbreak of measles in Geita district in 5 villages, in 3 of the 49 wards of the district. 75 children were affected. The cause of the epidemic was non completion of the vaccination schedule, families living far from a health facility (some of the children lived more than 8 kms from the health facility), and lack of mobile and outreach services.

11. Social Welfare and Social Protection

At the regional level and district level (District Executive Directors DEDs office) and at the district hospital, there is a Social Welfare officer. There is a National Welfare Plan of action but there is inadequate budget to undertake social welfare activities in the region. The main activity so far has been to map out Orphaned and vulnerable children, as with support from partners they prioritize support to the most vulnerable children. Once identified the children are kept in a special hostel, and other partners (NGOs) also cheap in to support the care of the children with shelter, food education and clothing. One of the challenges faced is that there is inadequate staff and there is no standard national tool to facilitate the mapping.

Other activities have included support to the poor and the elderly, especially with health services. Even though this group is exempted from cost sharing, they face problems because they are asked to buy medicines because of unavailability at the hospital and other lower facilities. This affects all groups that qualify for exemption. They have very limited funds to support these groups. The social welfare officers also support HIV/AIDs patients on ARV by providing them with food.

The concern expressed was the inadequate resources both human and financial compared to the needs of the communities and that the MoHSW do not concern itself with the social welfare section even when they visit the region/district.

12. Monitoring Evaluation and Research

The Monitoring and Evaluation framework is in place in come of the councils but is not implemented effectively, in part due to lack of transport to enable verification of data.

Some councils have a dedicated HMIS focal points while others do not and some staff have received training on HMIS. A HMIS focal person is available at the regional level. HMIS tools including registers, computer and a motorcycle are in place. In Bukombe DC, data is regularly verified by the CHMT during their weekly meeting. However, councils are concerned about the reliability of data provided by the facilities.

DHIS is in place in some councils and ISDS is in good progress. The ISDS focal in the region collects data regularly and submits to the RMO. Due to the lack of transport, the focal sometimes uses mobile phone communication to collect data from the districts. This mobile phone communication is not funded through the RHMT.

ICT systems are a challenge in the region due to poor connectivity and power shortages. Members of RHMT and CHMTs share modems and have used their own personal funds to purchase internet bundles. As a result e-health systems are not in place.

13. Other Issues: Capital Investments

Councils plan for maintenance and improvement of existing health infrastructure and equipment through their CCHPs; however, lack of adequate resources limits the investments that the councils can make. In practice, infrastructure is poor and councils are unable to purchase all the equipment they require.

Councils also highlighted how government procurement and tendering systems prevent them from efficiently using their available resources. Bukombe DC noted that it would be quicker and less expensive for the council to directly employ a local 'fundi' to complete minor repairs than it is to go government systems.

Guidelines for maintenance are at council level but not at facility level. Some health facilities cannot take initiative in maintaining infrastructure (minor repairs and fumigation) despite having cost sharing money balances. In Chato DC, a health centre had a beehive in one of its buildings and one ward had no doors. However, it was waiting for CHMT to act. The health facility is responsible for follow-up but slow procurement procedures apply and accessing cost-sharing funds, as indicated earlier, can be difficult and time-consuming. In addition, for certain medical equipment it is necessary for a technician to be sent from MoHSW – this can delay maintenance of essential equipment.

There is varying degree of functionality of equipment and other infrastructure for service delivery in the councils visited. Each of the councils complained of facilities in need of rehabilitation; having insufficient equipment; and having equipment of insufficient quality. Ambulances and transport for patients is a big challenge. Some facilities do not have the required number of wards or do not have a delivery room. Facilities are operating with inadequate numbers of beds, mattresses, autoclaves and instruments. Equipment provided through MSD is often of poor quality; staff complained of low quality mattresses, linen, stethoscopes, BP machines and forceps. In Chato DC, the x–ray machine has been out of order for over three years; a technician was sent from MoHSW but was unable to fix it due to a missing part that needed to be ordered. Councils have also reported a break in the gas supply which affects their ability to manage the vaccination system effectively in facilities. However, despite these challenges, staff members are continuing to cope and provide services. In Geita TC, the privately operated Geita Gold Mine health facility often takes x-rays for Geita TC and DC patients; however, there is no formal agreement for this assistance.

Expansion of the health infrastructure is progressing better in some councils than others; however, the rate of increase of facilities is too slow to reach the MMAM target of a health facility in each village. In Chato DC, six dispensaries and two health centres were built and one health centre renovated. Geita DC ("mother council" of Geita TC) has built one health centre and twenty dispensaries since 2009 (12 functioning, 8 waiting registration). The registration process can be lengthy and unregistered facilities are unable to access MSD services. There are also challenges in staffing and equipping the new facilities. One council noted delays in receipt of funding under MMAM.

A challenge highlighted by all councils is the need for community initiation of MMAM facilities. Councils do not have adequate funds to sensitize or mobilise community members and no guarantee that if the council does fund such an activity that it will lead to community incentive.

14. Other Issues: Medicines and Supplies

Facilities are not adequately supplied with equipment, medicines and supplies. As noted earlier, councils report that they receive poor quality equipment from MSD. Bukombe district received 10 faulty BP machines from MSD. Health facilities are also poorly supplied with medicines. Drugs are in short supply as the MSD undersupplies, rarely provided the full order and sometimes filling in less than half of the orders. The council is unable to purchase the drugs/supplies not provided by MSD as MSD does not issue the appropriate documentation necessary to allow the district to buy medicines in the private sector. Availability of tracer medicine is low.

When MSD does provide appropriate documentation to allow councils to procure in the private sector with council own sources/cost-sharing funds, costs vary from MSD. Some items are more expensive while others are less expensive.

Councils were very receptive to the proposed policy to have 30 per cent of funds available directly at the LGAs for procurement of supplies, external to MSD, as they believed it would lead to less stock outs at the district level.

Medicine Therapeutics Committees were in place at the district hospitals and councils are monitoring ADDOs. Some ADDOs are still awaiting accreditation. The CHMTs reported no major challenges with fake drugs being supplied in the districts. EML and STGs is functional.

The District Pharmacists in Bukombe DC and Geita TC reported coordinating with health facilities, hospitals and vertical programmes to ensure management of the drug supply and distribution.

15. Other Issues: ICT in Health DCh

Health centres and facilities do not have access to computers and manage all data collection in their registers. Bukombe DC has a dedicated focal for managing data at the council level, but this is not the case in all councils. As a result, data reliability is weak.

Access to internet is limited for the RHMT and CHMTs as a result of limited connectivity and associated costs. CHMTs do not have an ICT focal and depend on assistance from the DED.

E-health is not functioning.

Annex 1: Contacts and References

Table 3: Team Members

Professor Siriel Massawe	
Mr Dereck Chitama	
Dr Tengio Urrio	

Table 4: Geita Regional Health Management Team

Mr Lupandisha	Ag. RMO and the Regional health Officer
Mohamed Vunza	Health Secretary
FelistaKimaro	Acg. RRCHCO
ElisanteShumbi	Ag Regional Health Officer
Willie Luhangisa	RIVO
FaithmonWikindo	SWO-RS
Hemedimahamudu	Pharm-RS

Table 5: Geita Town Council

Dr MuseletaNyakiroto	Town Medical Officer incharge
RehemaKittoa	TRCHCO
MwashubirwaNestori	TIVO
George Ndokwa	TMFP
David Msahandete	T-Pharm
Japhet A Masesa	Ag THO
Noel Makuza	DMO- Geita District

Table 6: Kasamwa Health Centre, Geita Town Council

Dorothea Bissanga	Enrolled nurse-Ag.Nurse i/c
Peter Tindiwe	Clinical assistant
Flora sabanga	Nurse/midwife
Jeremiah A Mikoney	Clinical officer - Ag facility i/c
HadijaMjungu	Enrolled nurse

Table 7: Bukome District Council

MajalaKuboja	Ag. DPH
LadislausMagaso	District nutrionist
LadislausMadandi	Ag. DIVO
David H Majulla	Ag.DMCC
SemagogwaNikodemus	DLT
Gerald M Mwanza	D TB/HIV officer
Diana Sadiri	Ag. DRCHCO
Dr VedastusKilolonga	DEC
Eva S Kapelo	DMHC
UpendoMhoja	Ag.DNO
Dr HonorataRwezahura	CTC i/c

Elias Sumira	Ag. Hospital patron
Dr MandeLunnyekela	DDO
UafistAmon	District SWO

Table 8: Meeting with Bwanga Health Centre Staff Chato District

No.	Name	Designation
1	Selestina J. Inyasi	ACO
2	Anna Paul Nyakubina	EN
3	Samuel L.M. Kajoro	Lab Attendant
4	Bismark Aduol	CO
5	Aines Mavika	EN
6	Domitina Tizanga	NM
7	Joyce Kabanza	EN
8	Augustine John	MAttendant
9	Mary Suleman	EN

Guidelines Available in Districts in Geita Region

1. Ministry of Health and Social Welfare (2008) National Policy Guideline for collaboration TB/HIV activities
2. Ministry of Health and Social Welfare, National AIDS Control Programme National Guideline for HIV Testing and Counselling in Clinical Settings
3. Ministry of Health and Social Welfare (2012) National Guideline for the Management of HIV and AIDS
4. Ministry of Health and Social Welfare National Guideline for Management of Sexually Transmitted and Reproductive Tract Infections
5. Ministry of Health and Social Welfare (2006) Manual of the National Tuberculosis and Leprosy programme
6. Ministry of Health and Social Welfare National Guideline for the Management of HIV and AIDS
7. Community Led Total Sanitation (CLTS) (2006)
8. National Sanitation Options and Construction (2012)
9. Ministry of Health and Social Welfare (2011) Implementation Guideline for 'Vitamin A' Supplementation and Deworming
10. Ministry of Health and Social Welfare (2001) Cholera outbreak Control
11. Ministry of Health and Social Welfare Rotarix Vaccine and PC Vaccine
12. Ministry of Health and Social Welfare National Guideline for IMCI
13. Ministry of Health and Social Welfare National Health laboratories Strategic Plan 2009-2015
14. Ministry of Health and Social Welfare Infection Control and Infection Safety
15. Ministry of Health and Social Welfare Health Care Waste Management
16. Ministry of Health and Social Welfare

17. Ministry of Health and Social Welfare Template for developing Annual health Plans for Health Centres and Dispensaries.
18. Ministry of Health and Social Welfare (2007)
19. Mwongozo wa Taifa wa Kukinga na Kuthiti Maambukizi Katika Utoaji wa Huduma
20. Ministry of Health and Social Welfare (2010) National guideline for Home Based Care
21. Ministry of Health and Social Welfare (2007) Standard Treatment Guideline Tanzania Mainland
22. Ministry of Health and Social Welfare (2010) Medicine and therapeutic Communication Guideline
23. Ministry of Health and Social Welfare Mwongozo wa Usimamizi wa dawa Vitendanishi vya Upimaji wa VVU na Kiti za DBS (Dried Blood Samples
24. Ministry of Health and Social Welfare Human Resources Management, District Strengthening Training participants Guide
25. Ministry of Health and Social Welfare (2006) National Guideline for Malaria diagnosis and Treatment
26. Ministry of Health and Social Welfare (2009) National Guideline for Safe Disposal of Unfit Medicines and Cosmetic products
27. Ministry of Health and Social Welfare (2011) National Management Guideline for the Health Sector Prevention and Response to Gender Based Violence
28. Ministry of Health and Social Welfare (2007) Comprehensive Health Planning Guideline
29. Ministry of Health and Social Welfare (2011) Guideline for the Councils for Preparation of Plan and Budget for Nutrition 2012-2013
30. Ministry of Health and Social Welfare (2011) National Nutrition Strategy 2011/12
31. Ministry of Health and Social Welfare Tanzania Quality Improvement Framework 2011-2016
32. Ministry of Health and Social Welfare (2009) Quality Improvement, Infection Prevention and Control Orientation Guide for Participants