TEHIP News

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- **SPENDING ON HEALTH**
- A SOUND HEALTH PLAN
- **IMCI STRATEGY IN TANZANIA**
- HEALTH FACILITY REHABILITATION

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

Front Cover: Like most other developing countries, Tanzania's population, even in rural areas, is increasing faster than resources can cope. One of the main challenges to health planners is to ensure adequate quality health services to the people. Back Cover : Access to clean and safe water is a basic requirement in ensuring community health.

Dug out canoes are a common means of transport in Rufiji District, one of the areas where TEHIP tools support DHMTs in improving the quality of health services.

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Health Sector SWAps Milestones

1998

- ***MoH/Donors Health Sector Review Meeting.***
- ***First MoH SWAps Workshop.***
- ***Signing of Memorandum of Intent.***
- ***Agreement on Policy and Vision of the Health Sector.***
- ***Development and Costing of the Programme of Work and Plan of Action.***

1999

- ***Signing of Memorandum of Understanding between MoH and Partners.***
- ***Joint Disbursement System Developed.***
- ***Joint Disbursement System Operationalised.***

2000

- ***District Basket Disbursement System Completed***
- ***District Basket System Operationalised.***

Merging donors' funds gives Tanzania ownership of her health activities

One of the salient features of the Tanzania's Health Sector especially after the 1977 Al-Mata Declaration, that introduced and promoted Primary Health Care, was the proliferation of vertical programmes that addressed specific health problems. Much as the programmes delivered the intended services, often they did not work toward supporting nationally defined policies and strategies. Some donors operated programmes at primary levels without overall coordination by the Ministry of Health. Lack of coordination resulted to duplication, disintegration and overburdening of the health system at the district level. The programmes implementation generally contributed to uneven distribution of health care and services over the country at large.

As the process of health reforms gains momentum in Tanzania, the Ministry of Health is bracing to translate proposals into programmes of work for implementation. One of the mechanisms adopted to support the implementations is the Sector Wide Approach (SWAp). This is a long-term partnership in which development assistance is issued to support nationally defined policies and strategies through a collaborative programme of work. It calls for a complete shift from project to sector performance approach. SWAp implementation entails a commitment to shared goals, strategies and common management arrangements. To support this a Health Basket Funding Mechanism has been put in place. The Basket is a pool of funds from partnership stakeholders intended to support a common sector-wide approach. Nine out of 16 health sector donors are currently contributing to the health basket and 82 districts out of 114 are participating in its implementation.

Despite the pool of resources from various donors, the responsibility for maintaining a thorough and efficient system that ensures quality of health services falls upon the government. Unlike previous efforts to provide health services and care, the Basket marked the beginning of Tanzanian ownership of her health sector activities. Not only is the government now in the driver's seat of the Health Reforms, but it's also playing a crucial role in addressing equity in the provision of health services.

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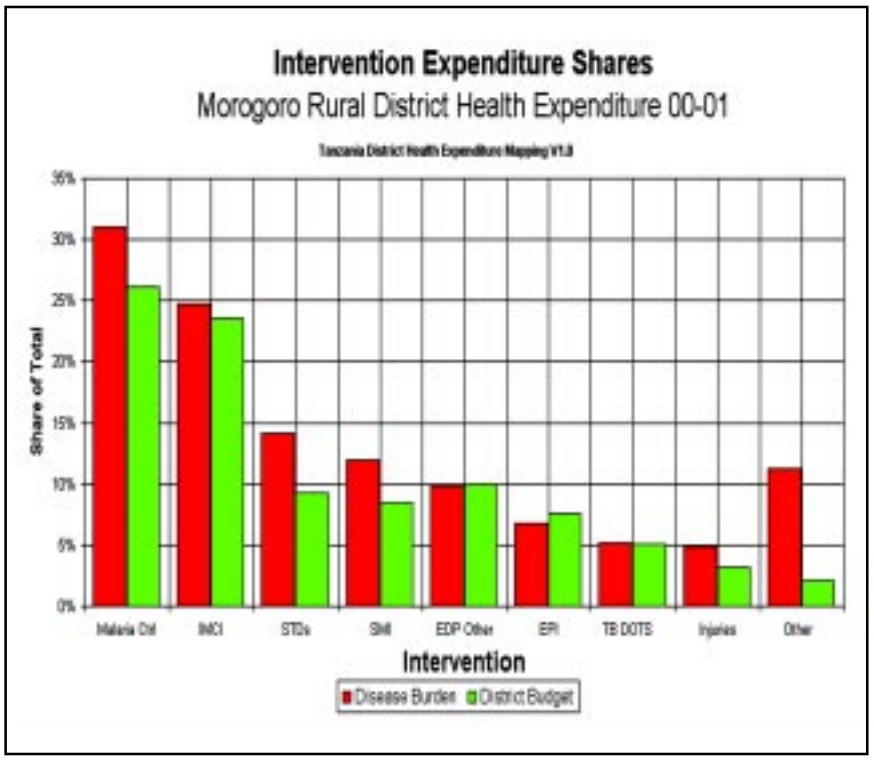
Health reforms in Tanzania expect Districts to move beyond just managing diseases, to managing health systems from a perspective of health equity.



TEHIP's simulated basket implemented, since 1997, has so far generated experience for basket funding approach to district health planning.

At the district level the Basket Grant effects are now increasingly being felt especially with the US$ 0.50 per capita disbursed to councils as non-earmarked funds to support implementation of health programme activities and US$ 0.15 per capita for the Medical Stores Department earmarked for drugs and equipment.

Apart from minimizing inequalities, the disbursement of funds on per capita basis has proved an incentive for meaningful health planning, improved health services provision and enhanced intersectoral collaboration. Districts that are making use of the Council Health Basket Grant have adopted the same financial rules and regulations as the government and the standardized procedures have proved helpful in fund disbursement as well as accounting and reporting.

In the districts where TEHIP has been collaborating with CHMTs in priority setting and resources allocation, lessons can be drawn on the applicability of the basket fund. After realizing that most districts were handicapped in health service delivery because they often had only salaries for health workers and drugs, Tanzania estimated that an investment of US$ 8 per capita would be needed to cover for modest health services. TEHIP, in the course of implementing evidence-based planning, offered US$ 2 per capita to top up the estimated US$ 3-4 in the form of a non-conditional basket grant.

TEHIP's simulated basket implemented, since 1997, has so far generated experience for basket funding approach to district health planning. There is evidence of how much incremental funding CHMTs could handle and above all, the experience has provided a realistic planning opportunity to CHMTs. It has shown that, indeed, districts planned on the basis of the US 2 per capita incremental funding but none was able to spend to the limit. But, at less than half of the amount made available, training and introduction of new interventions such as Integrated Management of Childhood Illnesses (IMCI), Insecticide Treated Nets (ITNs), TB DOTS, Safe Motherhood Initiative (SMI) and Sexually Transmitted Diseases Syndromic Management was initiated with increasing coverage and expenditure over time. The implementation of TEHIP's simulated basket also saw improvements in management, administration, communication, supervision and health facility infrastructure.

All in all, TEHIP experiences in Rufiji and Morogoro Rural look set to greatly inspire both the planning and use of SWAp Basket Funds when the tools are rolled out to all other districts in the country. It is important to bear in mind that basket funding is a mechanism that has to be phased in. It is a realistic option evidenced by the TEHIP simulated basket. However, the following aspects need to be considered:

- Capacity building, simple planning and support tools will greatly enhance the effectiveness of the basket grant.
- After 2 - 3 years of implementation, there is need to increase the level of basket funds since the capacity to utililze additional funds will have increased.
- There is need for the government to encourage more stakeholders to join the basket fund in order to minimize distortions and inequities in resource allocation.

Ministry of Health Calendar of Events

Date	*Event*
25 January	Leprosy Day
24 March	Tuberculosis Day
07 April	World Health Day
25 April	Africa Malaria Day
05 May	International Midwives Day
12 May	International Nurses Day
31 May	No Smoking Day
16 June	Africa Child Day
26 June	International Day Against Drug Abuse and Illicit Trafficking
11 July	World Population Day
07 August	SafeMotherhood and Breast Feeding Day
10 October	World Mental Health Day
01 December	World AIDS Day

Sector Wide Approaches provide an opportuinity to utilize resources more rationally.

SWAp pioneering new partnership

Aid coordination in the health sector has been restructured over the last two years by making it more transparent and improving its effectiveness.

The restructuring of the donor funding procedure to the health sector has entailed a gradual shift from project/donor approaches to Sector Wide Approaches (SWAp) in which partners are encouraged to finance the health sector Plan of Action rather than discrete projects. This is a long -term partnership in which development assistance is used to support nationally defined policies and strategies through a collaborative Programme of Work.

Even where partners are still financing projects, an attempt has been made to make the projects an integral part of the Plan of Action of the Ministry of Health and Local Government authorities, said Dr. F. Njau, head of the Health Sector Reform, Health Policy and Planning.

SWAp is a response to the need for more stable and a longer term financing framework for adjustment and producing coherent programme approaches. The approach is geared toward a common investment plan jointly with the partners in the health sector.

Specific achievements, that have been accomplished in the transformation of donor coordination are as follows:

- Undertaking Public Expenditure Reviews (PER). The re views have pointed out areas of weakness and strength in public health expenditure and assisted to advise and recommend the best option of allocating public finance in the health sector including grants and credits in the sector.
- Restructuring of the former Primary Health Care Secretariat into the Health Sector Reform Secretariat in the Policy and Planning Department with increased capacity to link health resources, both domestic and external in the health sector, coordinate health reforms and policy strategies and manage the transitional change.
- Routine monthly Health Basket Fund Committee and quarterly

Donor coordination in funding

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Health Sector Wide Approach Committee Meetings are held.

- Joint Health Sector Technical Review and main review are carried out twice a year by all stakeholders. The Review is an opportunity to share the Health Sector Medium Term Expenditure Framework and it facilitates co-ordination of the use of resources in the health sector.

Revision of Aid - coordination in the context of Sector Wide Approach has also met some challenges and problems. The challenges range from administrative and managerial to institutional. They could be summarized as follows:

a) Slow disbursement of Health Basket Funds due to teething problems of moving into the new systems of fi nancial management.
b) Over- stretching of the Health Sector Reform Secretariat in servicing parallel project review missions and other missions that are interested in the experience of the Sector Wide Approaches in Tanzania.
c) Parallel development of new systems such as the Integrated Financial Accounting Management System which are new and require new knowledge and skills.

The Ministry of Health (MoH) is responsible for health policy development, management of health SWAp and setting health norms and standards to be attained by all health providers to ensure quality of care in acceptable quantity and cost.

Per capita expenditure on health increases

Per capita expenditure on health shows a slight increase in actual spending.

A review of trends in per capita expenditure on health shows a slight increase in approved and actual spending from 1999 to 2001.

A draft Public Expenditure Review (PER) Health Sector Update for 2002 shows an increase from US$5.75 approved and US$5.52 actual spending in 1999/2000 to US$5.83 approved and US$5.88 actual spending in 2000/2001. Tanzania's Poverty Reduction Strategy Paper (PRSP) states that the health sector is a priority for the government.

The Review Team from the Ministry of Health with support from colleagues in the Ministry of Finance, other government staff and an external consultant also found out that there was a move in recurrent expenditure away from the regional to local government (up from 70 cents per capita in 1999/2000 to US$ 1.8 in 2000/2001.

A key result from the PER 2002 report is the trend in expenditure away from secondary and tertiary hospitals toward district-based health services.

However, the report submitted to the MoH by the United Kingdom Department for International Development

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Trends in expenditure shifting

Tools for apportioning resources now in place

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(DFID) Health Systems Resource Centre says more work needs to be undertaken to identify financing constraints and to cost the core activities required for the priority programmes.

Hitches to analyzing the performance of the health sector in Tanzania against stated policy priorities include "the current structure of the Ministry of Health budget and the fact that it is not possible to clearly identify priority programmes, or how they are funded across the whole health sector."

However, as per capita expenditure increases and districts continue to receive funds from various sources including the Health Basket Fund, articulate planning and management is required to ensure that the available resources are well spent. In districts, budget totals can amount to hundreds of millions of Tanzanian shillings to be spent on a myriad of activities. This makes budgeting and planning for health at the district level a complex process.

The Council Health Plan is often hard to interpret and does not give members of the funding partners a clear picture of how money is to be spent. To grapple with this problem, TEHIP which since 1997 has been implementing, in collaboration with CHMTs, evidence-based planning in Rufiji and Morogoro Rural Districts has developed a tool that allows CHMTs to collect and analyze information more effectively.

The District Health Accounts tool is designed to help CHMTs analyze their budgets and expenditures by providing a one-page summary and several graphical "pictures" of aspects of their annual plans. The tool is intended to help districts understand the accumulated total financial resources that they have budgeted (or spent) in their plan; the sources from which they expect their revenue; and the major interventions and activities to which these funds are allocated.

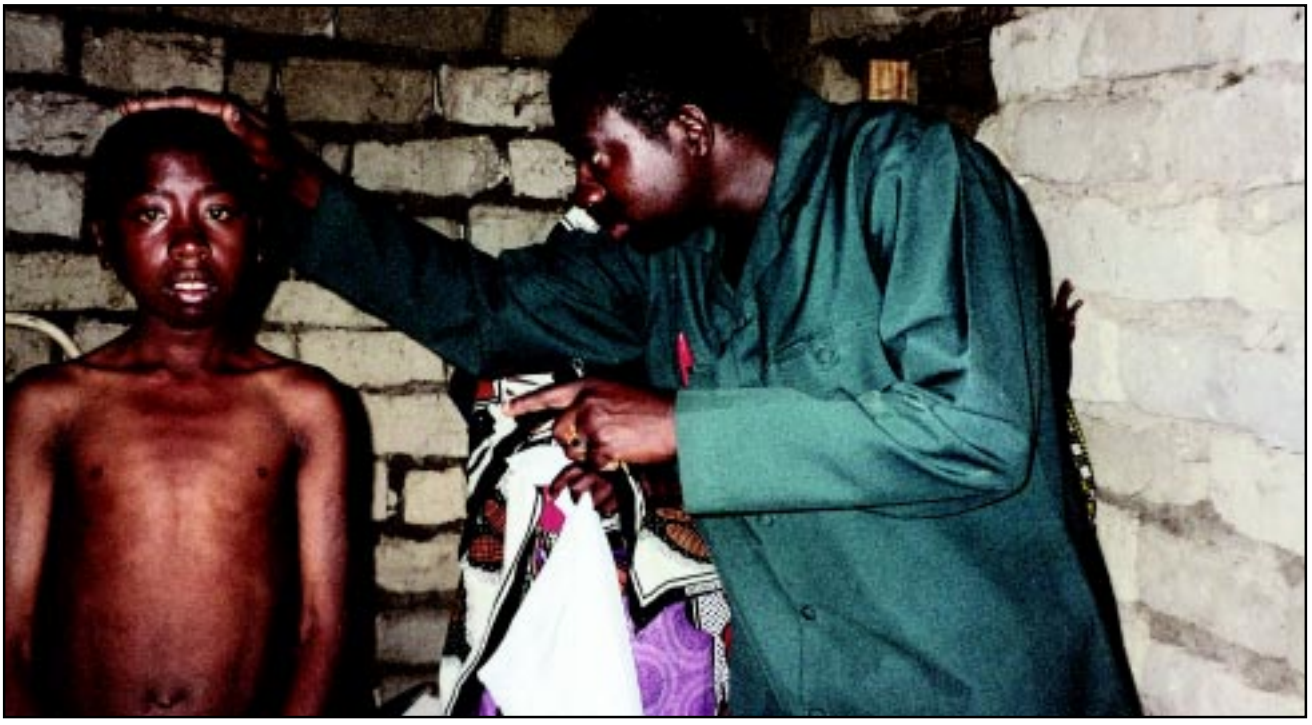
A tool has been developed that allows CHMTs to collect and analyze information more effectively.

It also blends well with another powerful and handy tool, the District Burden of Disease Profile . This aims to simplify, package and communicate complex information on vital statistics and the local burden of disease.

In Rufiji and Morogoro Rural districts, a combination of the tools has led to the CHMTs apportioning a 5-fold increase in the share of health resources used for the prevention and treatment of malaria, and among children under age five, a 20-fold increase.

With the government policy to spend more on health gaining momentum year after year, the roll out of the tools to other districts goes along way to ensuring that the resources are channeled to planned priorities.

An outreach service spreads the benefits of well planned health services.



Input for the Morogoro Health Plan was obtained from communities, front line health workers and other stakeholders.

How the Morogoro health plan was crafted

The adage 'to plan is to choose' is no longer just a catchphrase but a reality in Morogoro District. The 2002 Health plan for Morogoro District was judged by the MoH as one of the best in the country. It has involved many stakeholders including the participation and involvement of the community in the whole process. The District Medical Officer, Dr. Harun Machibya sheds light on the process they had to undergo in the preparation of the plan.

The Health Plan was prepared using the District Health Management Training Modules prepared by the Ministry of Health. It follows the "Ten Steps to a District Health Plan - a workbook for Council Health Management Teams (CHMTs)" designed by the Primary Health Care Institute based in Iringa.

The plan, as MoH requires, drew some input from Basket Fund Guidelines, the National District Health Planning Guideline as well as the National Health Policy developed by the Ministry of Health. Various references, including the Burden of Disease Profile and information from the Adult Morbidity and Mortality Project were used as evidence for the planning.

Input from communities, front line health workers and other stakeholders were obtained through stakeholders and district cascade zonal meetings. Focus Group discussions/Participatory Rural Appraisal (PRA) conducted by the CHMT in collaboration with TEHIP, were also invaluable inputs from the community.

A pre-planning workshop was conducted to evaluate the Comprehensive Council Health Plan (CCHP) of 2001 and compile relevant sources of information and materials for the health plan of 2002.

The situation analysis has attempted to address prioritized health problems. Strategies and objectives to overcome these problems and the current status of health services were also given.

The interventions together address about 89% of the Total Disease Burden of the population in the district.

Essential Health Interventions are:

- Integrated Management of Child hood Illnesses (IMCI) which address five leading causes of death - malaria, pneumonia, diar-rhoea, measles and malnutrition.

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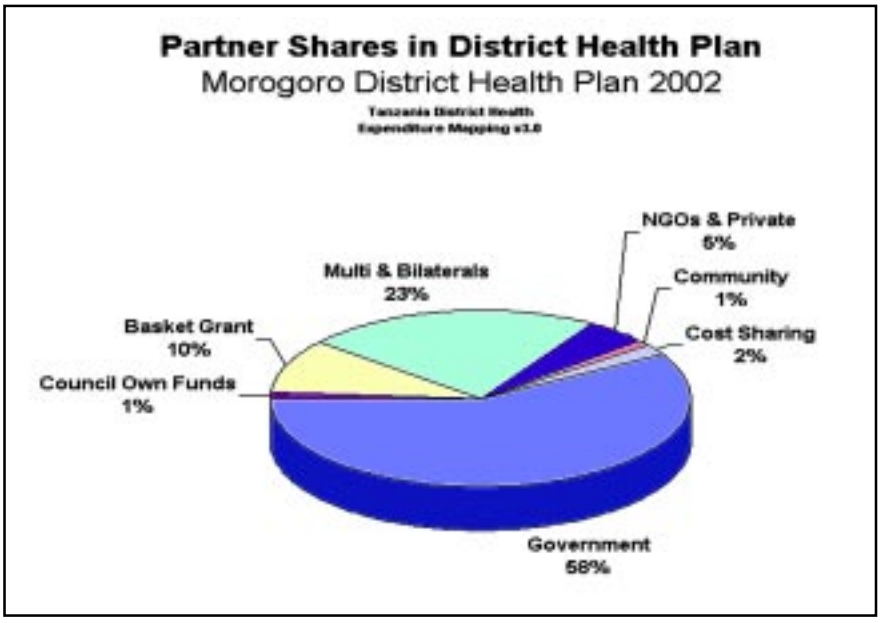

Involving stakeholders in planning

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- Case management and prevention for Acute Febrile Illness (AFI) including malaria, ITNs for prevention of malaria, Intermittent Presumptive Therapy (IPT) for prevention of malaria in pregnancy.
- Safe Motherhood Initiative (SMI). A relatively large share of the burden of disease due to deaths before birth are a cause of concern.
- STI Syndromic Management (for HIV).
- Expanded Program on Immunization (EPI).
- Essential Drugs Program/Indent System.
- Tuberculosis Direct Observed Therapy Short Course (TB DOTS).

The Implementation mainstay of the afore mentioned packages involves the increasing partnership of stakeholders at all levels.

Continued monitoring and evaluation through the cascade system will ensure continuous two-way communication with all the district Health facilities, to assist achievement of the plan goals.

What makes a health plan tick

Morogoro Health Plan has been classified as one of the best in Tanzania. Dr. Raphael Kalinga of the Ministry of Health says it is outstanding because it is:

- *Comprehensive.*
- *Curative, preventive, promotive and rehabilitative in its presentation*
- *Careful to explain very accurately and precisely all the funding sources.*
- *Precise in mentioning all stakeholders with their roles clearly defined.*
- *Implementable and realistic.*
- *Gender sensitive.*

Mozambique emphasizes stewardship role

Like Tanzania, Mozambique is bracing to reform its health sector and one of the approaches being emphasized to achieve quality and sustainable health services to all is the Sector Wide Approach (SWAp).

A working group was established to accelerate the adoption of this approach and recently the Mozambican Ministry of Health signed a code of conduct that set the rules of cooperation and specified also the desire of both the government and partners to adopt SWAp as a mechanism of collaboration based on national policies and strategies.

According to the Mozambican presentation during the 34th Commonwealth Regional Health Ministers' Conference held in Dar es Salaam in October 2001, there is a gradual shift from project to programme approach as donors are increasingly recognizing the importance of looking at the sector as an integrated system.

"SWAp is in another perspective, a way of putting the government in the driver's seat. In this position the government is more likely to exercise its stewardship role, it was noted.

WHO defines stewardship as a function of government responsibility for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizenry.

While playing that role the government provides clear policy direction and vision; regulatory function; and facilitates information gathering and use for policy making.

Mozambique's social and health indicators are below the average of sub-Saharan Africa. The country is greatly dependent on donor aid and therefore the move toward SWAp is an important step in the country's donors mutual relationship.

IMCI: A broad strategy

In April 2002 the Ministry of Health organized a mid-term review meeting to assess the progress of the Integrated Management of Childhood Illnesses (IMCI) implementation and to develop another plan of action for the second and last term of the Five Year Strategic Plan.

IMCI is a broad strategy that encompasses a wide range of interventions for reducing mortality and morbidity associated with the major causes of childhood illnesses, namely: malaria, diarrhoea, measles, acute respiratory infections (mainly pneumonia)and malnutrition.

The IMCI strategy entails three main components:

1. Improving case management skills of health workers through provision of guidelines on IMCI and training in standardized procedures and follow-up of trained health workers.
2. Strengthening health systems by ensuring availability of drugs and other supplies, improving organi zation of work at the health facility level, improving monitoring and supervision, and strengthening referral systems and referral care.
3. Improving household and community practices for child survival, growth and development with focus on health seeking behavior, compliance with prescribed treatment, proper home care of sick children and general health promotion.

IMCI encompasses a wide range of interventions aimed at reducing mortality and morbidity.

The implementation of the IMCI Strategy started in Tanzania in early 1997. It was designed to take place in three phases, namely: Introduction, Early Implementation and Expansion.

The introduction phase involved adaptation and translation of IMCI generic materials to suit the local needs of the country. It also involved review of national programme specific policies to be consistent with the objectives of the IMCI Strategy.

Another significant activity of the Introduction Phase was identification of "Early Use" districts to start IMCI implementation and provide lessons for large scale application of the strategy in the country. The seven districts that were selected were; Morogoro Rural, Rufiji, Muheza, Igunga, Mpwapwa, Korogwe and Magu.

The early implementation phase entailed training of health workers in the seven early use districts.This also involved strengthening of health systems in the early use districts.

In May 1998, the Ministry of Health organized a desk review meeting to assess the progress of IMCI implementation in the Early Implementation phase. The meeting developed a five-year strategic plan (1998-2003) and a two-year plan of action to guide IMCI implementation in the expansion phase.

Implementation rolls out to more districts

Case Management Training and fol-low-up of trained health workers have been the main activities of the Integrated Management of Childhood Illnesses (IMCI) implementation in Tanzania.

Over 3,300 health workers, both in-service and pre-service, have been trained in IMCI in Tanzania and by the year 2000 about 80 per cent of eligible personnel had been followed-up at least once. As a result of the training, case management and counseling skills of health workers have been improved.

At least one training site has been identified within each of the 38 out of 42 IMCI implementing districts. Three national training sites exist in Arusha, Kibaha and Morogoro and a total of 108 IMCI case management courses have been conducted using these training sites.

According to the Mid-term Review Report on the implementation of the IMCI strategy in Tanzania, there has been rapid expansion of the strategy within the implementing districts and also to other districts in the same region. The strategy has also expanded to new districts in new regions.

The report issued in April 2002 says that 42 out of the 93 oriented districts are at different stages of IMCI implementation and most of them already include IMCI in their health plans.

The Ministry of Health, has trained a total of 293 IMCI facilitators of which 67 and 56 have been identified and trained as Course Directors and Clinical Instructors respectively, using the apprenticeship method. This has made it possible to roll out IMCI to the 42 implementing districts country wide. It has also helped to scale up IMCI training in pre-service institutions since 45 percent of the trained facilitators are tutors in pre-service schools.

Most of the achievements, made in the implementation of the strategy are however, a result of organizational and management initiatives at the Ministry of Health. The creation of an IMCI unit helped to institutionalize IMCI within the existing structure of the Ministry of Health. The Government has created a budget line to the unit and the amount allocated to the unit has been increasing gradually during the past three years. This support has enabled the unit to implement activities that have given impetus to IMCI implementation on a national scale.

Ministry of Health hails collaborators

Allocates budget line for IMCI

The Ministry of Health has adopted the Integrated Management of Childhood Illnesses (IMCI) as one of the main approaches in addressing childhood mortality. Remarkable progress has been achieved in its implementation.

With grim statistics of under-five mortality standing at a rate of 147 per 1,000 live births Tanzania is one of the countries with high childhood mortality. The main causes of death of children are malaria, diarrhoea, pneumonia, measles and malnutrition.

Opening the IMCI Mid-Term Review Workshop, Dr. Ali Mzige, Director for Preventive Services in the Ministry of Health, said the Government of Tanzania, in collaboration with her various partners, have been supporting IMCI implementation across the country in various ways.

The Government has allocated a budget line for IMCI which is one of the essential interventions within the National Essential Health Interventions package. To date 93 of the 114 district councils have been oriented on IMCI and 42 of these are at different stages of implementation.

IMCI has also been included in the teaching curricula of Allied Health Schools, Nursing Schools and Muhimbili University College of Health Sciences. More than 3,000 health workers have been trained in IMCI and 80 per cent of them followed up at their working places to reinforce their skills.

Availability of essential drugs for managing sick children has been improved. An IMCI community component has also been launched.

The Director, on behalf of the Tanzanian Government, thanked all collaborators who have supported Tanzania in implementing the IMCI interventions particularly UNICEF, TEHIP, GTZ, USAID, GDS, MSF, AFRICARE, AMREF, NPA and PLAN International.

An IMCI community component has been launched.

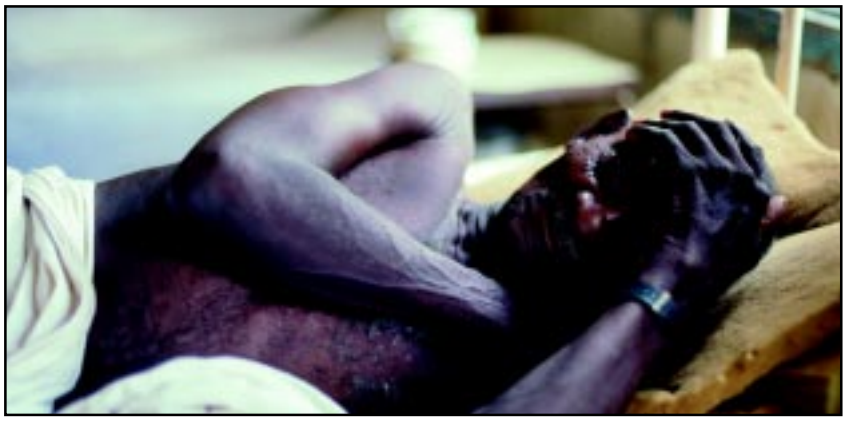
CHMT takes action to lower maternal deaths

Morogoro Rural District has plans to reduce maternal mortality by 10% from the current 9.77/1000 live births by year 2005. The ratio at the national level is between 5.29 - 6.00 per 1000 live births.

In the implementation of the work plan, the Council Health Management Team has approved the following strategies:

- *To increase the number of health facil-ity deliveries from 50% to 70% by December 2002. The strategy is to promote involvement and participation of all stakeholders in maternal care.*
- *To strengthen the referral system from the community to 98 health facilities.*
- *To increase family planning acceptance rate from 15% to 20% by December 2002. The strategy is to improve family planning services to 98 health facilities.*
- *To promote community involvement and participation in maternal care to 42 wards in the district.*
- *To improve nutritional status of pregnant and lactating mothers to 42 wards.*

Indent System: Pulling in the necessary drugs



Uniform kits did not necessarily meet the requirements of all health facilities catchment areas

Under the Essential Drug Programme (EDP) implemented in Tanzania during the past 17 years, health facilities across the country received standardised pre-packed kits of drugs to meet what was perceived to be their monthly needs. The pre-paid kits packed with an assortment of drugs, at the Medical Stores Department in Dar es Salaam are dispatched to all districts to be issued on a monthly basis to health facilities operating under the auspices of the Ministry of Health.

These uniform kits did not necessarily meet the requirements of all health facilities catchment areas which may differ in climate and disease patterns. A health facility in Morogoro Region , for example, where malaria is a major health problem, often ran short of the anti-malarials provided through the kit, within the first two weeks of the month while they had in excess other drugs that were not in demand.

Drug over or under supply coupled with cost sharing issues raised concern among stakeholders and led to a revisiting of the system. An order-based supply system that allows health centres and dispensaries to order drugs according to their needs was designed and approved for testing in 1998. The proposed arrangement known as the Indent System is almost a reverse of the EDP "push system" for provision of drugs at the Primary Health Care level in favour of a "pull system" anchored at the districts health facilities.

This new arrangement that provides adequate response to epidemiological and demographic differences in various parts of Tanzania entails an operational, organizational and managerial structure for drugs provision. It was piloted in Morogoro Region since May 1999 and afterwards implemented with success in some of the crucial aspects of the system.

According to Dr. Harun Machibya, Morogoro District Medical Officer, the Indent System has already shown its strengths over the EDP standard pre-packed kits. "The earlier arrangement was wasteful. It did not sufficiently meet the needs of health facilities. While it failed to meet basic drug requirements in some areas, it supplied in excess drugs that are of no use to our district."

In Morogoro, Dr. Machibya said that , health facilities overburdened with malaria almost invariably faced a shortage of anti malarials but had an over-supply of Vitamin A tablets and folic acid that were not in high demand. The losses due to provision of drugs that are not relevant or over-supplied in the pre-packed kits are substantial.

Piloting of the system in Morogoro has provided the MoH with the necessary tools for decision making in matters concerning the actual budget, sharing of costs and exemption costs even though the pilot phase and initial implementation did not involve payment of drugs by facility users.

After the pilot phase, the Indent System Development Team is of the opinion that the System could continue as envisaged in the initial design for five years but recommends that:

- A progressive continuation of a "pull" system be initiated and allowed to be comprehensively tested in order to acquire the best tools for decision making on further policy development in respect of drug financing and service improvement.
- Cost sharing be introduced as soon as possible. The community should be allowed to play a role in the financing of health services in order to develop a rightful demand for quality health service provision.
- The budget savings by MoH on a well arranged pull system should either remain in the drug sector or be used to improve the PHC level structure.
- Harmonization of different programmes should precede concurrent implementation in order to serve the common health care goals.
- MoH should consider to raise the service level requirements for the PHC staff in order to increase the potential for success of a pull system.

Implementation of the Indent system has also revealed some areas that need to be further strengthened. For example, it is important to ensure that tools such as register books are in place so as to have proper records to support and justify facility orders and use of drugs. After the pilot testing phase was completed in Morogoro Region, health facilities faced difficulties in meeting requirements of the Indent System as facilities lacked basic tools. However, Dr. Machibya believes that those are teething problems that can be dealt with using available resources. "Our follow-up work has already been easier with tools such as the Integrated Management Cascade," one of TEHIP's management tools that has improved communications among the district health facilities.

Ministry of Health clarifies changes on malaria treatment

The Ministry of Health has clarified the recent changes made with regard to malaria treatment policy in which Sulphaxodine Pyrimethamine (SP) replaced Chloroquine as the first line drug for malaria treatment.

Winding up her budget speech for the Financial Year 2002/2003, the Minister of Health, Hon. Anna Abdalla reiterated that the use of Chloroquine has been suspended because it was failing to cure six out of 10 cases of malaria and sticking to a failing drug risked increased death rates due to malaria.

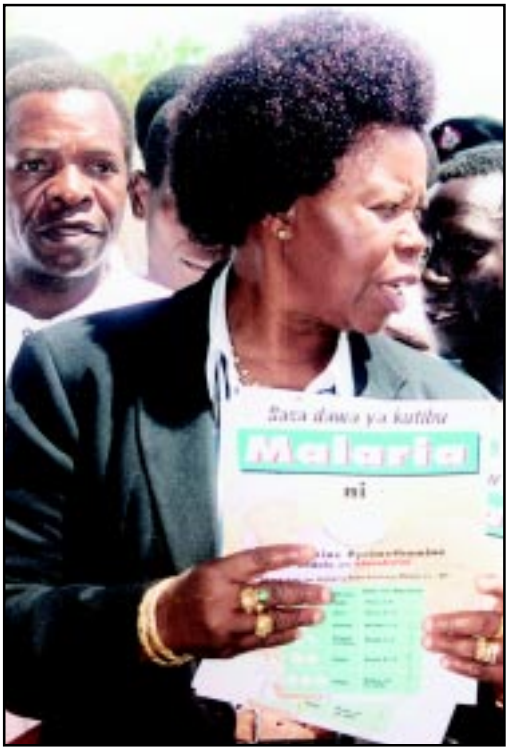
The decision to replace chloroquine with SP was based on research findings that indicated SP to have a cure rate of 85 to 90 percent and the fact that it is a more cost effective alternative compared to other anti-malarials.

The use of Chloroquine as a remedy for malaria spans over 60 years. During those years malaria parasites gradually became resistant to the drug. At the moment many malaria cases would not be cured by the use of chloroquine.

Research undertaken since the 1970s to determine the level of resistance of malaria parasites to chloroquine confirm the rising trend. While in 1979 resistance was 12 percent, in 1995 resistance had increased twofold to 24 percent. From 1998 to 2000 resistance had risen to 52 percent. This is evidence that chloroquine is no longer a useful remedy for malaria and cannot therefore be recommended for its treatment. This is in line with a World Health Organization recommendation that if the level of treatment failure to an anti-malarial drug reaches 25 percent, a country should implement a replacement for the drug.

From 1998 to 2000 the Ministry of Health tested the efficacy of two anti-malarial drugs SP and Amodiaquine. Both were found to have lower resistance rates compared to chloroquine. Malaria treatment guidelines have thus been amended as follows:

- SP is the first line drug
- Amodiaquine is the second line drug
- Quinine is the third line drug, but in cases of severe malaria quinine is the drug of first choice while Amodiaquine is the first line drug for those patients who, for one reason or another cannot use SP.



Hon. Anna Abdallah, Minister of Health

The Ministry also recommends the use of SP in pregnancy for prevention of malaria for pregnant women and the unborn child. Research has shown that pregnant women, living in malaria endemic areas who receive intermittent doses of SP during their pregnancy enjoy better health and have healthier babies than women from the same areas who had not had such treatment.(National Malaria Medium Term Strategy Plan, 2002-2007).

The Ministry meanwhile, has embarked on intensive research on newer ways of treating malaria with a combination of drugs in order to improve treatment outcomes and curtail emergence of resistant parasites.

There is evidence however that if every child in Tanzania was to use an Insecticide Treated Net (ITN), 30,000 lives would be saved yearly and malaria episodes would go down by 50 percent.

HIV prevalence monitored in Tanzanian sentinel sites

In Tanzania the prevalence of HIV infection from 28 antenatal clinic sentinel surveillance sites for the year 2000 ranged from 4.2% to 32.1%.

A total of 6,505 antenatal clinic attendees were recruited for 2000. Of the 28 reporting sites countrywide 22 (78.6%) had HIV prevalence of less than 10%. Prevalence continues to fluctuate within sites showing no specific trend.

The National AIDS Control Programme HIV/AIDS/STI Surveillance Report of January to December 2000 indicates that the urban site which for the past nine years had a decreasing trend, registered an upward surge in 2000. The relevance of the single observation of an upward tendency in 2000 needs to be ascertained by further studies.

The age specific HIV prevalence among antenatal clinic attendees for 2000 was highest in the younger age groups 14 - 24 years and 25 - 34 years. The high age specific prevalence in the age group 14 - 24 years is an indicator of high incidence of HIV infection in the respective surveillance communities.

Sentinel surveillance utilizing antenatal clinic attendees was established in 1990 when 24 sites were established in 11 out of the 20 regions of Tanzania mainland.

How valid are VA forms?

A report has been produced which examines how well people in the community understood the language used in the 'verbal autopsy'(VA) interview.

The VA is the central tool for the attribution of probable cause of death in the National Sentinel System (NSS) for burden of disease surveillance.

VA interviews are conducted with family members and relatives of deceased residents in several areas of Tanzania and one key factor affecting the reliability of the VA is clear communication between the person conducting the interview and the person being interviewed.

If the interviewee does not properly understand the questions on the VA form in the intended way, the VA will not perform as expected in eliciting the probable cause of death. NSS is in the process of validating three VA forms for children and adults.

The purpose of this study was to assess local comprehension of all relevant questions on the VA forms through observations and an open-ended-interview format.

The aims were:

- To indicate whether there were any major shortcomings in the phrasing of questions on the VA forms being developed with and for the NSS.
- To identify specific areas of confu sion or misunderstanding.
- To pinpoint any necessary revision of the language used on the VA forms themselves.

The Adult Morbidity and Mortality Project (AMMP) team conducted observations and comprehensive interviews in Dar es Salaam, Hai and Morogoro Rural NSS areas to assess whether there were any items on the VA that were a source of confusion, or of poor or non-comprehension on the part of many informants.

There were a number of questions that confused just about half of the respondents.

In the comprehension interviews, some terms and questions were confusing to 50% or more of the respondents with at least one of these questions on each of the forms.

A total of 16 items elicited poor or non-comprehension in 20 - 30% of the respondents. These items were spread across all three forms.

The comprehension interviews produced some 'clusters' of confusing questions. These were questions about chronic disease and some respiratory signs; gyneacological signs and symptoms; and differentiating among different types of methods of treatment.

The team has generally concluded that the results of this comprehension exercise present the opportunity to carry out some fairly minor re-wording of specific sections and questions on the VA forms.

While it is doubtful that the team could develop a VA form that will be universally understood by all participants, this exercise will certainly help to optimize the VA used in Tanzania NSS.

VA interviews are conducted with family members and relatives of deceased residents in several areas of Tanzania.

Rehabilitation of facilities continues to benefit from community support

As health facility rehabilitation continues to advance, more facilities in both Rufiji and Morogoro Rural districts are benefiting from community planning and support

In most areas covered by the project, people have come to realize that they can work for their own development and external aid is useful only as a stimulant to their own efforts.

Lusanga dispensary after rehabilitation.

The new looks of a rehabilitated health centre at Ngerengere, Morogoro Rural District.

Over 30 facilities across the two dis tricts are in different stages of con struction or repair in a spirit of self reliance and making efficient use of external resources.

"We are glad that we get assistance whenever we ask for it. It may take a long time, but assistance is always in the offing at the end of the day," said Mzee Said Abdallah (72) as he encouraged youths to participate in the construction of Lusanga Dispensary in Turiani Division.

Construction of the dispensary is 98 per cent complete and the building looks new with all needed facilities in place and people are enjoying the efforts of their work.

It was a carnival atmosphere at Lusanga, as villagers joined members of the Morogoro Council Health Management Team in the handing over ceremony of equipment to the recently completed dispensary built by the community.

In their message to the District Medical Officer, Dr. Harun Machibya, villagers said they have realized that the people can only bring development themselves if they work together towards a set goal.

"We were determined to build this dispensary and we have done it," said a cheerful village chairman as he received medical equipment worth more than Tsh.2 million from Dr. Machibya.

Dr. Machibya told them that he was happy that they have set a good example in building the dispensary and called upon them to maintain it so that it operates within set standards.

The equipment handed over included hospital and delivery beds, suction and BP machine. Lusanga is in Diongoya ward, Turiani Division.

TEHIP News

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

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