HEALTH SECTOR REFORM

SITUATIONAL ANALYSIS OF 37 DISTRICTS FOR THE FIRST PHASE OF HEALTH SECTOR REFORM

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1.0 EXECUTIVE SUMMARY

1.1 Preamble

This study was a collaborative undertaking between the National Institute for Medical Research and the Ministry of Health. The main aim was to obtain baseline information for 37 districts to be involved in the First Phase of Health Sector Reforms. The information is to be used to inform and guide the process, as well as providing a basis for evaluation of the impact of Health Sector Reform in the future.

The data was collected by DHMT in each of the 37 districts. During the process two meetings were conducted. The first meeting discussed the catalogue and the methods of data collection. The second meeting took the form of feedback in which the results were discussed with DHMT. The meetings involved NIMR supervisors. In each of the study district, three catalogues were filled out. A copy was given to DMO's office for local use, another copy was given to the RMO's office in the region involved. The research team retained the third copy.

1.2 Main Findings

1.2.1 Health Services, Diseases and Demographic Profiles

1 The infrastructure to provide basic primary health care packages is inadequate in some districts. Forty percent of the districts reviewed have dispensaries with no delivery units and 30%, do not have MCH units.

2 Distances from some facilities to the district hospital make referral system impossible and unrealistic. In Monduli district for example a patient from one of its health unit will need to travel about 260 km to reach the district hospital in Monduli town. This raises the question on whether the management of health services and referral system should follow the political boundaries for each district. Overall, the referral system is weak and not followed.

3 Reproductive health is widely available in all the districts. TBAs play a major role in delivery care, TBAs conducted 92% of all home deliveries. In terms of birth control the most widely used methods are Pills (32%) and condoms (29%).

4 Over 80% of all health facilities in the districts provide basic child health services i.e growth monitoring and immunization. Lack of funds was reported as the main constraint affecting adequate provision of other forms of child health services such as diarrhoea treatment corner and vitamin supplementation.

5 Immunization coverage varies widely between the districts reviewed. The lowest coverage was observed in Kiteto (48%) and the highest in (100%) in Arusha, Morogoro and Ilala.

6 An average of five percent of all the children below five years of age in the study districts were underweight.

7 Most common communicable diseases in the study areas include malaria, diarrhoea diseases, acute respiratory infections, tuberculosis, HIV/AIDS, cholera, typhoid, skin infections, intestinal helminths and eye diseases. Malaria is number one health problem in the districts with epidemics being reported during the past five years in some districts. Outbreaks of cholera, meningitis, plague, rabies, and dysentery have been observed in some districts. Plague was reported for the first time in Masasi district in 1998.

8 Incidences of some immunizable diseases such as measles and polio were reported in Kondoa, Monduli, Singida, Songea and Tabora districts.

9 Non-communicable diseases such as chronic cardiac failure, diabetes, hypertension and asthma are on the increase particulady in urban districts. Epilepsy is the most common mental health problem in all districts, particularly in Morogoro, Ulanga and Dodoma districts. Drug abuse is a major problem in most urban districts.

10 Dental caries is the most important oral condition in all districts.

11 There were broad range of health related interventions in the study districts. A notable feature in most districts is that the meaning attached to these programmes vary widely between the districts. In Ulanga and Morogoro districts for example, school health programme include a broad range of disease control activities with malaria and schistosomiasis taking an upper hand, while in other districts (Kiteto and Kondoa) these programmes are mainly health education and surveillance activities.

1.2.2 District Health Infrastructure and Capacity

1. A very substantial difference was observed between districts in the number of vehicles available relative to their respective service populations. One vehicle for example, serves about 300,000 people in Morogoro urban, compared to one vehicle per 8,000 in Ulanga district.

2. Overall, 49% of all the facilities require major repairs, 23% minor repairs, 12% are in good condition, and 16% operate in rented facilities.

3. All the DHMTs in the study districts acknowledged the relatively weak structural maintenance system and poor infrastructure and recommended for prompt major improvements and investments.

4. Most (68%) health facilities also lack basic amenities such as water, adequate working space, light and ventilation.

5. Water supply and sanitation facilities were acknowledged to be the main problems across all the study districts.

6. Overall the communication (telephone, fax, e-mail and radio call sets) system is weak and often affected by frequent breakdowns and power cutts.

1.2.3 Community Health Promotional Activity and Community Participation

1. The collaboration between health managers and service providers and the community is constrained by lack of clear collaboration framework. The community involvement is translated as monetary contribution, whereas voluntary work physical participation like construction of latrines and peer health education.
2. There are water committees in almost all the rural districts responsible for dealing with water problems.
3. Village health workers operate under difficult conditions. The most vivid difficult conditions shortage of working facilities, recognition by the formal health care staff and working space.

1.2.4 District Financial and Management System

2. The proportion of revenue obtained from local, central government and donors was not uniform in all districts. The proportion of receipts depicted a large variation from district to district. While more than 80% of funds in Singida for example, came from the RAS, in Mwanza 90% of all the funds came from local government.
3. Large variation exists in allocations per capita between the districts reviewed, ranging from TSh 4502 (Iringa Rural) to TSh 34 (Kinondoni) with median of TSh 568.
4. Data on actual allocations and expenditure are not adequately kept. Most DHMT in the study districts experience difficulties in obtaining requested data and in some (see for example Babati) the data was not available.
5. There were no cost tracking system in any of the study districts.
6. DED, Municipal directors and heads of various programmes within the districts had relatively extended financial control compared to those of DHMT.
7. On the basis of discussions with various DHMT there were no system of collective decision making (involving all DHMT members) regarding routine expenditure.
8. The most common items of expenditure were personnel, travel cost, fuel, drugs, equipment and maintenance. Personnel emoluments are the most expensive item consuming 80% of the district health budgets. This makes service provision in the study districts difficult since there are very limited amount of funds for other items such as supplies, fuel and equipment.
9. In urban areas the DMOs have dual responsibility that include the management of health services in the urban as well managing rural districts surrounding their respective urban areas. This was found to be the case for Lindi, Sumbawanga, Shinyanga, Mtwara and Songea. The inclusion of Urban DMOs in the rural districts poses a great potential for improving co-ordination however, urban DHMT's fear that this might increase their workload and over-stretche their management capacity.

10. There was also ambiguous relationship between RHMT and the municipal authorities. Also noticed, was a complicated relationship between DHMT and RHMT in the municipal and town councils.

11. The actual management system is diffused. The DMO is the overall person responsible for health at the district however, his/her working relationship with members of the DHMT as well as the chain of command is not clear.

12. Relatively small proportions of supervisory visits were carried out by the DHMTs. A large variation was observed between districts. Iringa urban conducted a total of 17 visits in each health facility in 1998, Lindi (9), Kiteto (8) Kilwa (12) while in Sumbawanga, Kisarawe and Songea only one third of all the facilities were visited once during the year.

1.2.5 The Private Sector

1. Very limited information was available in the reviewed districts regarding the contribution of private sector to health service provision in the districts reviewed.

1.3 MAIN CONCLUSIONS

1. Maternal and infant mortality rates vary greatly between the districts implying very varied health status levels within the country.

2. A major problem exist in collection, handling, storage, retrieval, up-dating and access to the data on basic vital statistics.

3. There is still inadequate infrastructure to provide basic primary health care packages in some districts. Forty percent of the districts reviewed do no have delivery units, similarly thirty percent did not have MCH units. In addition, distances from some facilities to the district hospital make referral system impossible and unrealistic. In Monduli district for example a patient from one of its health unit will need to travel about 260km to reach the district Hospital in Monduli town. This raised the question on whether the management of health services and referral system should still follow the political boundaries for each district. Overall, the referral system is weak and not followed.

4. Immunization coverage varies widely between the districts, implying a relatively large problem of access and use to health service in some districts. Despite the elaborate immunization program in all of the study districts, incidences of some immunizable diseases such as measles and polio have been reported by some districts. Limited achievements have been made with regard to control of malaria, diarrhoeal diseases, acute respiratory infections, tuberculosis, HIV/AIDS, cholera, typhoid, skin infections, intestinal helminths and eye diseases. There was for example, a marked increase in the average smear positive tuberculosis cases in all districts. Such infectious diseases constitute a big health burden to the study districts. Among the most common communicable diseases, malaria is number one health problem in the districts with epidemics being reported during the past five years in

some districts. Outbreaks of cholera, meningitis, plague, rabies, dysentery still occur in some districts. Plague was reported for the first time in Masasi district.

5. There is an increase in non-communicable diseases such as chronic cardiac failure, diabetes, hypertension and asthma especially in urban districts. Epilepsy is the most common mental health problem in all districts, particularly in Morogoro, Ulanga and Dodoma urban districts. Drug abuse is a major problem in urban districts.

6. Dental caries is the most important oral condition in all districts.

7. The meanings attached to school health and youth friendly service programs vary greatly between the districts and they are accorded low priority

8. Research activities are sporadic and are not the mainstream activity in the districts reviewed. In addition the information regarding private sector in general use, and access is not integrated with the district health information system. Very limited information was available in the reviewed districts regarding the contribution of private sector to health delivery in the study districts.

9. Staff allocation to the Public/Government health facilities is not based on explicit criteria. This leads to unequal allocation of trained staff per capita as observed in some districts

10. Guidelines and mechanisms for community participation/involvement and the actual expectations both from the community and care providers were not available in any one of the districts reviewed. This was noted to cause unrealistic expectations among the care providers on what community is expected to do and contribute. To some extent, the relationship between health managers and the community is weak and ambiguity still exist on the role and functions of village health workers within the current health services reforms

11. There are standard and uniformly applied funding rules with effect that creates large differences between the districts. The lack of system that tracks expenditure by cost items limits the assessment of effectiveness in the use of funds obtained. Accounting for funds used by health department and monitoring flow of funds remains problematic. Personnel consumes almost all financial resources earmarked for health, leaving very limited funds for fuel, drugs, equipment and maintenance. Auditing is still limited to financial accounting – the current systems has no methods for linking services consumption and other outcome to resources spent.

12. Current system for vehicle allocation is not equitable and does not reflect actual population needs. This explains the observed phenomenon that shows substantial differences between districts in the number of vehicles available relative to their respective service populations.

13. There is no system in place that will allow for regular maintenance of the facilities. Even those repairs that could be done through local initiative are currently not carried out.

14. The system that allows linking water department and the district health services is weak. Water supply and sanitation facilities were acknowledged to be the main problems across all of the study districts.

15. The communication system linking districts and within districts require major restructuring. This may need to include the overall communication concept and approach. The current communication system is weak and often affected by frequent breakdowns and power cuts.There were very few districts with e-mail system.

16. The variations in the nature of activities carried out under the umbrella of health interventions in the study districts show that there are no guidelines describing the minimum and the range of activities expected in each district.

17. Management guideline is lacking regarding DHMT in urban areas. The inclusion of Urban DHMT in the Rural districts has great potential for improving co-ordination but all urban DHMT's said this increases their workload and over-stretches their management capacity. In addition, the systemic of organization of services at the district level and roles of various actors, including a system of accountability is weak. Supervision system is weak and small proportion of supervisory visits were carried out.

1.4 RECOMMENDATIONS

1. Additional capital investment is required to address some of the basic infrastructural problems for the basic primary health care package in some districts.

2. Distances from some facilities to the district hospital make referral system impossible and unrealistic. A policy decision is necessary to justify whether the management of health services and referral system should still follow the political boundaries for each district.

3. Major infectious and non-infectious diseases of public importance including tuberculosis and HIV/AIDS still pose political, social, cultural, managerial and scientific challenges to the districts reviewed. More effort should be put in provision of better and simple techniques for prevention and control of these scourges..

4. There is an urgent need to explore the basic malaria epidemic predictive factors and establish a sustainable surveillance system.

5. The meanings attached to school health and friendly youth service programs vary greatly between the districts and they are accorded low priority. There is a need for review of the basic concept of school health and friendly youth programs

6. Research activities at the district level need coordination. Currently these activities are sporadic and are not integrated in the mainstream activities in the districts reviewed.

7. Routine health information system need to be modified to allow inclusion of private sector contributions to health service provision, including service use, the actual coverage and manpower levels available.

8. A large variation on the number of trained staff per capita was observed between the districts in this study. There is a need to streamline the procedures for manpower allocations and adhere to the existing explicit criteria based on the needs

9. Mutual relationship between health managers and the community should be strengthened based on realistic expectations. The expectations may need to be defined by a charter between the two within the current health services reforms

10. Ministry of Health should establish a clear health services financing system in which the proportion of revenue from each potential source is pre-determined. Such system should also ensure same levels of resources per capita in each district.

11. System of handling and tracking data on fund allocations and expenditure must be established and data on spending must be adequately kept and made accessible.

12. Consensus system on use of financial resources between the DHMT and DED, Municipal directors and heads of various programmes is needed.

13. The substantial differences observed between districts in the number of vehicles available relative to their respective service populations imply great inefficiency. System of allocation of cars and other transport facilities including investment must be based on clear allocation formula which take into account the population size and geographical nature and referral complexities in each district.

14. Ministry of Health should reinforce the system that will allow for regular maintenance of the facilities using both local (village, districts councils) resources as well as national resources.

15. The system linking water department and the district health services needs strengthening. This might include exploring the possibility of resources from water departments to improve water supply at the facility level. This is also an area where donor input might be crucial.

16. Inter-sectoral collaboration within and between districts should be established and strengthened.

17. Ministry of Health needs a guideline describing the nature of activities being carried out under the umbrella of health interventions at the district level. This should define health interventions and describe the minimum and the range of activities expected in each district.

18. Ministry of Health must strengthen the use of existing management guideline and review the aspects related to DHMT in urban areas to limit their workload and over-stretching of their management capacity.

19. The system of organization of services at the district level and roles of various actors, including a system of accountability needs to be reviewed and strengthened.

20. Supervision system requires a major review. New design need to make realistic targets reflecting resources that can be mobilized on sustainable basis. Over-reliance on donor support appears to make the current system operate on ad hoc basis.

21. Investment is needed at the district level to improve data collection, handling, storage, retrieval, up-dating and accessibility. This may take the form of adding a staff among the DHMT who will be responsible for data acquisition and management.