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Ministry of Health and Social Welfare

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

Mbeya Region Field Visit

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

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Acronyms

ADDOS	Accredited Drug Dispensing Outlets
AMO	Assistant Medical Officer
ANC	Antenatal Care
BEMONC	Basic Emergency Obstetric Neonatal Care
CBO	Community Based Organisation
CCHPS	Comprehensive Council Health Plan
CD4	Cluster of Differentiation 4 (glycoprotein)
CHMTS	Council Health Management Team
CHSB	Council Health Service Board
CPD	Continuing Professional Development
DED	District Executive Director
DMO	District Medical Officer
EH	Environmental Health
FBO	Faith-based Organisation
FP	Family Planning
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit
HF	Health Facility
HFGC	Health Facility Governing Committee
HMIS	Health Management Information System
HRHIS	Human Resources for Health Information System
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
ITN	Insecticide-Treated Net
JHI	Joining hands Initiative
KfW	Kreditanstalf fur Wiederaufbau (German development banking group)
LGA	Local Government Authority
MCC	Mbeya City Council
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (The Primary Health Services Dev. Prog.)
MOHSW	Ministry of Health and Social Welfare

MSD	Medical Stores Department
NGO	Non-Governmental Organisation
OOP	Out-of-Pocket
OPRAS	Open Performance Review and Appraisal System
PICT	Provider Initiated Counselling and Testing
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
PSI	Population Services International
QIT	Quality Improvement Team
RCH	Reproductive and Child Health
RHF	Regional Health Forum
RHMT	Regional Health Medical Team
RMO	Regional Health Officer
STI	Sexually Transmitted Infection
SWO	Social Welfare Officer
TBA	Traditional Birth Attendant
TIIS	Tanzania HIV/AIDS Indicator Survey
TIKA	(Tanzania employees health insurance)
TTV	Tetanus Toxoid Vaccine
USAID	United States Agency for International Development
WIT	Work Improvement Team
ZHRC	Zonal Human Resource Coordinator

1. Introduction

1.1 Composition of the Team

Mbeya Team members of the HSSP III MTR comprised Dr. Sheena Crawford, Ms. Priscilla Matinga, and Dr. Eli Nangawe accompanied by Mr.EliudMwaiteleke from PMORALG. On the ground, the visiting team was facilitated by the Regional Medical Officer, Dr.SeifMhina, The Regional Health Secretary, Ms Juliana Mawalla, and the Regional Health Officer, Mr. Peter Meleki. The five day programme was preceded by a participatory planning of the week on the day of arrival, and preliminary orientations and document review. The process followed, was open discussions guided by the field visits checklist (annexed). After an initiation meeting with the RHMT, visits were made to Mbeya City, Rungwe and Ileje CHMT and health facilities. These visits gave the team a chance to make snapshot observations and hold discussions with staff and some community members/ clients.

1.2 Field Trip Objectives:

- To identify the achievements of HSSP III to date and assess what made these achievements possible
- To identify challenges to efforts for improving access to quality health services and improved social welfare, and to assess how these challenges are being addressed
- To identify broad improvement opportunities for the remainder of HSSP III
- To use field information to strengthen recommendations for the development of HSSP IV.

1.3 Method

To collect information and understanding, the field trip followed a process that encompassed:

1. Literature review of District Comprehensive Council Health Plans, and other relevant documents
2. In-depth consultations with stakeholders at Region, District, Health Facility (purposively selected hospitals, health clinics and dispensary) and in communities
3. Consultations with selected civil society organisations
4. Feedback session with key stakeholders to discuss findings

2. Mbeya Region Profile

2.1 Administration and Demographics

Mbeya region has 10 district councils including Mbeya City, Kyela, Rungwe, Mbarali, Ileje, Mbozi, Chunya, Mbeya DC. New councils are Busokelo and Momba. The region has 28 Divisions, 214 Wards and 832 villages and 181 streets (lowest level of local governance).

According to Census of 2012 the regions had a total population of 2,707,410 under one year are 116,858 and under five are 543,795 and women of child-bearing age (15 – 49 years) are 663,143 and growth rate of 2.6%.The region has 415 H/Fs including hospitals, H/Cs and dispensaries, out of these 82% provide MNCH services. Population distribution per Council, number of villages and wards can be sourced from the National Bureau of Statistics.

2.1.1 Health Services Coverage

MMAM still lags behind, especially in the the more remote areas (such as Ileje). MMAM still lags behind, especially in the the more remote areas (such as Ileje). According to information sourced from the Mbeya Regional Health Officer, 448 out of 843 villages have a health facility while there is 35 health centres existing in 218 wards of Mbeya region.

2.1.2 Functionality of HFGCs

In theory, HFGCs arE established and functioning. However, as in other areas, meetings may not always be held – because of lack of incentives, sitting and transport allowances (see section 11, below).

2.1.3 Traditional Medicine Practice Status

In Mbeya city, there are numerous traditional medicine outlets and practitioners. Attempts are made to regulate these (licencing). In all areas, the poorest people are those most likely to resort to traditional medicines, which they perceive as cheaper. Where there is no nearby service (e.g. Ileje) women are most likely to use TBAs. In some areas, there are attempts to licence TBAs. In others, women may be fined for failing to give birth in an HF.

2.1.4 Health Infrastructure Status

There have been improvements over recent years but many challenges remain (see below).

2.1.5 Water Supply and Sanitation at Health Facilities

In Mbeya City, protection of water sources is good. Solid waste management needs attention throughout the region (see below). The percentage of households with improved, sanitary latrines was not available, but is unlikely to be above the national average (c. 3%)

2.1.6 Essential Health Services Package

The CCHP provides guidance to health facilities to abide by the Essential Health Services Package content as a basis for service priorities. RCHS and HIV testing services are integrated (The PMTCT

services in the ANC; TB and HIV and AIDS services in OPD including PICT). VTC operate as a parallel service with better infrastructure and relatively new equipment. Various partners supported projects are coordinated and included in regional and districts plans.

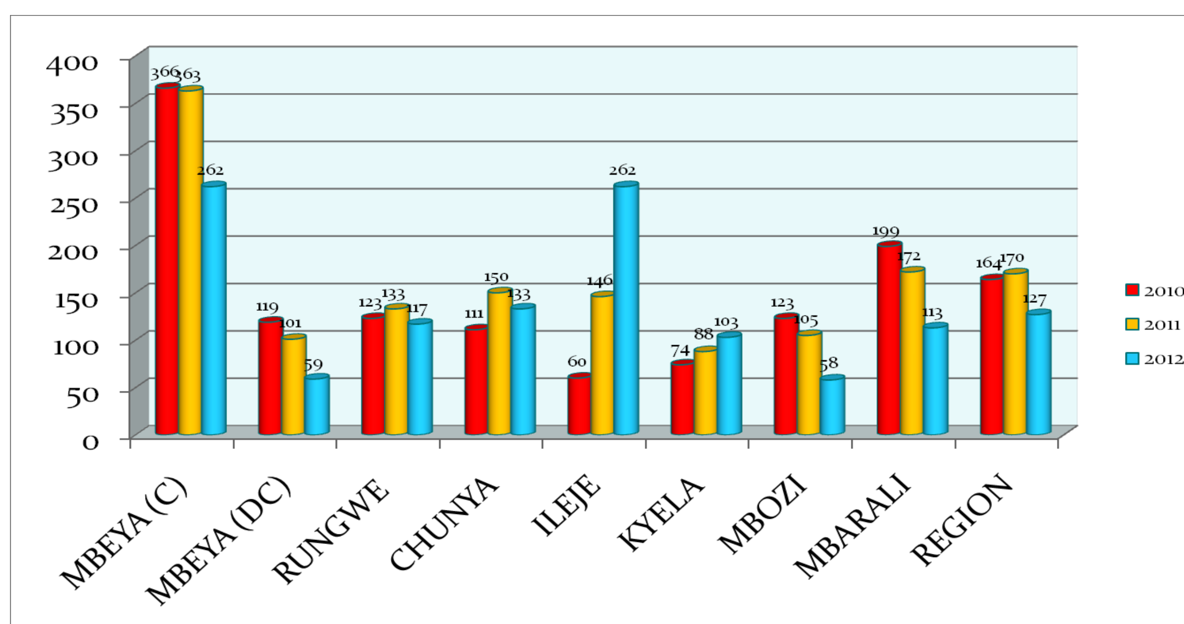
2.1.7 Health Achievements

Self-reporting claims the following achievements on key health indicators:

Table 1: Mbeya Region Maternal death ratios by Local Council from 2010 to 2012

Indicator	2011	2012
Maternal deaths recorded in health facilities	140	99
Neonatal deaths per 1000	9	8
Perinatal deaths per 1000	16	15
Health facility deliveries %	45 (2010)	58
Family planning CYP	1,924,554	2,735,832
DPT-HB3 coverage %	97	96

Figure 1: Mbeya Region Maternal death ratios by Local Council from 2010 to 2012



2.2 Management of District Health Care

CHMTs develop, track implementation of, and report quarterly on progress of their CCHPs. The RHMT monitors and supervises the respective Districts (Councils) health work using the CCHP as a basis, weaknesses in supervision notwithstanding (regularity of financing, supportive supervision capacity issues). Non-availability of transport poses limits to referral and supervision in some areas. Where supervision of health facilities is done, it has administrative emphasis and is less technical. There have been instances of by-passing the Region in some tasks as shall be seen in findings below.

CHMTs are responsible for supervising and supporting Health Centres' and Dispensaries' infrastructure and services. How they involve these lower levels in the CCHP process was

Ward Development Committees exist facilitated by the LGAs O&OD process to come up with their plans. Whether these plans are harmonized with the CCHP could not be ascertained. Councils have been trained in use of Plan Rep. Financing however still faces challenges due to late disbursements which is related to timeliness of reporting.

2.3 The Regional Health Management Team and Regional Referral Hospital

2.3.1 Coordination and Information Sharing: RHMT and RHF

An RHMT with eloquent leadership is in place, fostering coordination and collaboration with Local Government and Partners, as well as PPP, through creation of a "Regional Health Forum"(RHF). During the visit, the team attended the two-day RHF in Mbeya (25th and 26th July 2013).

The RHF was observed to facilitate information sharing with, and between, districts particularly on researched themes and new initiatives. Supervision is undertaken quarterly but is more administrative than technical. Feedback from the region to districts, on status of CCHPs and adherence to budgets, may be ignored by districts. The most recent assessment of CCHPs has by-passed the region, thus undermining its sphere of influence and supervisory authority over the districts.

RHMTs role is mainly advisory and has a low level of authority vis-a-vis district. Districts now have strengthened capacity; the RHMT has undergone initial rounds of capacity strengthening in planning - they need to be brought to the same level of capacity as districts and to be given higher level capacity in data use and analysis. The remark that DMOs can be transferred without knowledge or consultation with the RMO was a clear indication of limitations in the nature of collaboration, coordination and control.

2.3.2 Regional Referral Hospital

Hospital reforms lag behind in terms of prioritized strategic plans, specialized human resource placements and technological resource investment affecting actual fulfilment of referral capability at Region. The Regional Hospital plan has been developed, but there are challenges in securing financing.

Other Regional Hospital challenges include:

- Making available Medical, Paediatric and Maternity wards and requisite specialists (so far have only one; gap of 4).
- Proper mental health services are lacking
- Lack of portable X-Ray, and insufficient beds – 2 to 3 patients per bed.
- Whilst GIZ supports 15 Hospitals in the Region, the Regional Hospital Board has not yet been established legally.

The Regional Hospital introduced a block payment modality for services, as an alternative to several pay points, and thus managed to increase revenue up to 76% (User fees increased by 60% and NHIF 130%).

2.4 Central Level Support

In-service training is conducted to orient Districts (Councils) to technical guidelines issued by the MOHSW as these come out periodically. The problem lies with too many guidelines and the low capacity of oriented staff to relay the messages of the guidelines to the lower levels.

ZHRCs have assumed their role of in-service capacity building in the area of HIV/AIDS; this has not extended sufficiently to other health themes.

MOHSW interaction with Councils and Regions on CCHPs gained increased attention. As mentioned elsewhere in this report, delay in release of funds has been the main concern of districts.

Sharing analysed information is not systematic: As HMIS data are transmitted to higher levels, horizontal analysis is not done; neither is there formal feedback from the higher levels. Use of data/ information at the point of collection is still not happening (data perceived as the DMO's needs).

Ad hoc supervision visits have been experienced more as facility inspection rather than as more positively inclined supportive supervision.

3. SPECIFIC FINDINGS OF THE MTR TEAM

3.1 Human Resources

The region has a deficit of 45% professional staff with variations in severity from one council to another.

Leadership and planning: Health Secretaries are the HR planning and management Focal Persons in CHMTs with a supervisory and coordinative link at RHMT level provided by a Regional Health Secretary. The Focal Persons find it challenging to manage the Human Resource portfolio because of an existing mismatch between requested vacancies (by CHMTs), approved positions (by POPSM), postings (by MOHSW) and recruitment (by LGAs).

3.2 Human Resource Management

3.2.1 HRHIS

Districts have been oriented and trained in using the new HRHIS, but the system is still in the process of being tidied up and some facilities (private for profit) have not yet forwarded their HR data. The HRHIS is web-based and accessible but some limitations have been set – for example, it is possible toenter new recruited staff but not to enter district data in the event of a split district. The HR information is limited in application due to incompleteness and hence is of inaccurate and limited usefulness for HR planning. Overall the HR gap is prevalent in every district, and HR gap closure is gradual. HR information feeds into the LGA MTEF: All public sector staff is catered for in the LGAs MTEF, in terms of annual budget projections.

Sense of ownership of the HRHIS: Most of the users take it as the Ministry system or JICA system and others need special incentive to do the data entry and systems updates.

Collection of data from private and FBO's facilities is sometimes problematic; in some districts it is difficult to get data from them.

iHRIS was introduced under PMO-RALG (DED) by Intrahealth (USAID), but it has similar functions to HRHIS and therefore there is duplication in reporting. [Reg Health Sec. discussion at RHForum]

3.2.2 Capacity Building and CPD

In-service capacity building is paralysed. CPD is driven by individual effort – no systemic initiatives in evidence. HR Focal Persons monitor HR availability, arrange placements but have limited role in addressing HR capacity building aspects. HR research analysis capacity was not seen to be in place.

3.2.3 Effective Utilisation of Staff

Some Nurses are taken to serve in stores or the pharmacy, taking them away from core services and further reducing the availability of skilled health providers in facilities. Work schedules and time management systems were not in evidence. Absenteeism is common, motivated by allowances-endowed activities and personal issues. The quality of care in facilities is often not good owing to demoralised staff, no promotion, no extra duty allowance and issues with salaries.

3.2.4 Attraction and Retention

The incentive structure includes a range of measures meant for retention (from housing to various allowances, solar power and transport). But there are differences between councils in how these measures are used. In Mbeya City there are 17 dispensaries which do not do deliveries because there is no housing for staff: the Council has just finished building 2 staff houses and soon 2 dispensaries will start offering deliveries.

There are no retention policy guidelines followed. HR planning is done by the CHMT without involving FBOs and NGOs. As a consequence FBOs have a smaller number of professional staff relative to the workload.

3.2.5 Performance Monitoring

There were mixed feelings about OPRAS. Those people who think it is too cumbersome, are unable to articulate the benefits of the system. This is because the promised link to promotions is not realised, the too many copies required per staff per district creates a budget constraint. Analysis of OPRAS information, in order to generate systemic solutions on HR performance enhancement and management, has not been done; valuable experience and lessons that need to be documented are not captured– currently these lessons are being lost.

The HR Steering Team for the region is a positive innovative move that fosters collaboration with Private Sector and LGAs; It has potential to be optimised for improving HR management practices.

3.2.6 Training Institutions and ZHRC

There is one AMO School, five Nursing, one Dental, Clinical Assistants' and Laboratory Assistants' schools. Coordination of AMO, Nursing and Dental Schools, at Mbeya City, is leading to optimised availability of staff for teaching, in collaboration with Partners. The AMO School has a strategic plan that has not been costed. The Schools have staffing gaps (teaching and support staff) and operate on the basis of borrowing; in this sense they are in state of indebtedness some for 2 to 3 years running. Infrastructure maintenance needs vary case by case. Tukuyu Nursing School is fully accredited by NACTE.

Continuing education: Over the recent period, there were many applicants for the exams but few candidates took the examinations. In the districts, there is little (if any) CPD.

The Zonal Health Resource Centre is represented by the Principal of the AMO School. She is not aware of any support available for the Zonal structure, or how support would work. There is no budget and there are no activities, apart from occasional supervision of schools.

TIIS is not known and hence not yet used.

Jhpiego has started training for unskilled staff to ensure they do a better job, since there is a shortage of skilled workers.

- Understaffed and indebted Training Schools severely limit the ability to offer CE and in-service training as part of the ZHRC network.
- The ZHRC is sub-functional, with no contribution to CE, CPD and QA in education.

3.3 HMIS, Research

3.3.1 Progress and Difficulties

There has been orientation to new HMIS. HMIS data are now used in developing the CCHPs, and in early detection of epidemics. The HRHIS is new, the focal people being the Health Secretaries. There is a number of difficulties:

- It seems HRHIS is not linked systematically to the HMIS;
- CHMTs trained using old HMIS books;
- DHIS II training for wider team not started;
- New HMIS books have arrived but districts have been advised to wait until training has taken place (planned to take place mid-August 2013 or October 2013) - this implies that HMIS reporting for 2013 will be adversely affected.
- HMIS is at a standstill at district-level, but monthly disease surveillance, immunization, RCH, CTC, TB, reported separately by respective coordinators or focal persons, is on-going.
- Supervision therefore monitors data in a siloed and fragmented way (by specific programme entity)
- Health Facility staff have the attitude that HMIS data are solely for the DMO.
- Late arrival of registers; late reporting from private facilities.

The RHMT recommended that government should harmonize HRH information and other data management tools.

3.3.2 Conclusion

Parallel reporting requirements remain e.g. for vertical programmes and partners. This undermines the routine HMIS. Increased workload from the fragmented reporting affects accuracy and completeness of data, rendering the system unreliable. A need to achieve an integrated routine HMIS is the focus of current HMIS revitalisation effort, and should receive greater emphasis.

4. Disease Control

4.1 Disease Levels

HIV levels are higher than expected, at 9%, and do not appear to be decreasing. This is in part because availability of drugs means that people are living longer, in part because more cases are being detected and, in part, because there are issues in the services.

The approach to TB prevention and control is no longer vertical; follow an integrated approach. Now TB is to be included in plan – so there should be more access to medicines There is now enough TB screening. The intention to capture more and break transmission chain. USAID have assisted to build a lab which is assisting in TB detection.

TB Dots works. 92% cure rates.

4.1.1 Service Issues Affecting Disease Control

Nevertheless, there is a range of issues which seriously affect the region's ability to maintain and use proper disease control measures. In brief, these are:

Table 2: HIV and TB

Disease	Issues
HIV	▲ CD4 machines don't work ▲ DEFA machines broken ▲ PIMA machines available – but equipment is expensive so not yet used ▲ Niverapine OS for 4 months ▲ Citizens report stigma against PLWHIV
TB	▲ Quality of care is an issue ▲ 5 ways to be implemented in order to improve quality is missing so this is affecting quality of services offered to clients because there are not enough wards. Failure to control transmission of TB as general patients are mixed in same ward, including those with infectious TB. ▲ In <u>theory</u> collaboration with HIV (but few facilities implement this) ▲ Have lab but no local lab technicians only 2 Kenyan technicians ▲ [Few] isolation units – so do not cut off transmission ▲ 2 recent resistance cases identified

5. Medicines and Supplies

5.1 Stock-Outs

Frequency of stock outs, owing to various factors, poses the most prominent threat to quality of service delivery and limitations in meeting client expectations. The MSD sometimes does not follow the schedule of distribution of medicines. As a result there are stock outs in health facilities. Also, at times, what was disbursed does not tally with what is available at health facilities. Sometimes Health Facilities get only 2 quarters' worth of drugs per year

Reporting on drugs is poor, but MOH+USAID have trained 2 people per facility.

GIZ supported a study to identify the cause of drug shortages, and the commissioner was shown how drugs are lost. Disciplinary warning letters are written to those affected/concerned with drug loss. District have done audits. The process leading to penalty for disappearing drugs requires 3 warning letters (no case has reached 3 yet.)

5.1.1 Example of Good Practice

Despite these difficulties, some HFs are developing good practice models. For example, Ileje District Hospital has constructed a new drugs store and system – with ample space and good security. However, at Ileje, no stand-by fridge was noted. This is a standard requirement for cold chains; MOHSW is responsible for supplying fridges. Requests have been made but as yet there has been no response.

5.1.2 Other Issues

- Ferrous Sulphate has not been available for the last month in Ibaba.
- Nevirapine has been unavailable for more than 4 months
- No BCG vaccines in past 3 months (Mbeya City, Rungwe)
- Inadequate medicine especially for maternity ward, and insufficient gloves.
- CD4 machine not working at Mbeya City
- No cartridges for puma machines so they are not being used
- No operating microscope at hospital.
- Insufficient equipment: inadequate delivery sets, no resuscitation table, incomplete delivery kits

Citizens' expectations of quality health services are difficult/impossible to meet under such critical shortages

6. Financing

To date, in the districts, there is little that demonstrated efficiency and effectiveness in use of financial resources.

6.1 Insurance

Experience on health insurance schemes tested at district were shared. The example from Mbozi was claimed to be well-documented but the documentation was not readily available to the MTR for study. CHF enrolment is very low (only 6%) in the region; the RHF participants resolved to put more effort into stimulating membership, with extensive community advocacy and sensitisation through enhancing understanding of Councils on the PPP concept and its applications.

6.1.1 CHF

According to the RMO the prevailing confusion over CHF account management needs to be cleared and all Councils need to be allowed to operate the accounts to avoid jeopardizing the system. CHF was not popular in the HF facilities visited (e.g. in Rungwe). In Ikuti Health Centre, up to June 2013, only 59 families (out of a catchment population of 11,000 people) were registered with CHF. Staff says it is impossible to motivate people to join CHF when there are not enough drugs available, and when there is no evidence of matching funds and no one knows where CHF money is.

CHF now is said to have risen to 7.5%. The increased enrolment in CHF noted recently, has been influenced by beneficiaries of the KfW supported scheme for insurance to pregnant women. At Igawilo HC/Hopsital, over 700 women have been enrolled in the KfW scheme (so, CHF will extend to their families).

However, there appears to be a deal of confusion about how CHF works in relation to the KfW cards. HF-level staff were not able to explain this clearly (three different stories were given in three different places), even though they are registering women, and consider the scheme to be (so far) successful. In Igawilo, 766 women had been registered by the time of the visit. The SWOs have to fill in the forms and check that the women meet the criteria (according to them). But, they think that it would be better if all pregnant women were eligible (which they are).

The assumption is that KFW cards will lead to continued family enrolment in CHF after free 2nd year. But it is unclear how much ongoing health promotion will be given (and, without external funding, it won't, as there is no budget). Experience of similar schemes elsewhere, suggests there will be a high drop-out rate without ongoing promotion.

6.1.2 NHIF

Staff in the districts reported good enrolment and use of NHIF. In Rungwe and Ileje, NHIF wards were visited. These have single-occupancy rooms, en-suite, some with TV. It was noted that there were few patients in these wards, whilst the maternity wards in the HFs were over-crowded.

6.1.3 Research

There is evidence of operational research been conducted by districts around issues of insurance (CHF in particular), medicines and supplies (ADDOs) and management practices (Regional Hospital paying points).

6.2 P4P

P4P policy has been advocated but application is constrained because funds are not available.

7. Quality of Service

7.1 TQIF

In the region, there is some evidence of TQIF application (some posters, QIT/WIT structure, sharps disposal system and other IPC measures), but accreditation has not yet been embarked upon. Some protocols are observable but Kiswahili versions are rare.

7.2 Clients Service Charters

Two statements were seen, posted on walls, but in inappropriate places and in English. Notices explaining clients' rights to complain were seen in two facilities – phone numbers were given (however, neither staff not clients seemed to have any idea about whether anyone used the system).

7.3 Implementing Quality Standards

Essential Health Package knowledge fades at lower levels. Vertical programmes integration in CCHPs has happened BUT in implementation, there is only partial integration. Hospital reforms lag behind but all hospitals (Government and FBOs) have been trained on quality improvement and it was reported that QITs and WITs are in place (but there was not enough time to verify this). There has been limited and piecemeal reach to Health Centres and Dispensaries on quality improvement aspects.

The Regional Referral Hospital is limited in its ability to handle referral cases and so refers all maternity cases to META Hospital (a private facility). META provides all services for maternal care including neonatal care. The Regional hospital has been upgraded to a referral hospital in name only but does not meet requisite standards for a referral hospital: There is only a paediatrician available, no wards for neonates, nor a postnatal ward. Three months ago there was no SP, this month SP is available, but will expire this August.

The Join Hands Initiative (JHI) assists by providing an ambulance to improve hospital referral. According to the Matron there are inadequate maternity facilities, no linen cupboards, no equipment for continuing education. They lack Medical Wards (strained to the extent they use a conference room as a ward).

Eye Care: No microscope and so cannot do cataracts; One doctor, but has no equipment. Trachoma cases referred to the Consultant hospital.

NTDs: Five diseases are tackled: Schistosomiasis, Onchocerciasis, Lymphatic Filariasis, Trachoma and Soil Transmitted Helminths. Communities are involved. Good progress, negative parasitaemia achieved for Oncho and Lymphatic Filariasis. Technical report – not readily available.

Mental Health: Lack of qualified staff. All mental health patients diagnosed are sent to the referral hospital – however, at local level, they are all diagnosed with "psychosis", as staff does not have the skills to deal with mental health issues.

The summary impression is of an under-resourced Regional Hospital not functioning as a proper referral facility. Clinical mentoring has not been offered. Given staff gaps (specialists) at Regional Hospital, this is critical.

Stock-outs of medicines and other supplies and professional staff gaps are the most prominent factors having a negative effect on quality of services.

8. MNCH Services

Overall, there has been improvement in MNCH services in Mbeya over the period. In Mbeya city, for example, facility-based births are running at over 100% (extended catchment with women coming from other areas). However, there are still many aspects of services which cause concern.

8.1 Traditional Birth Attendants

There is no consensus policy on TBA roles in Mbeya. If they are excluded, there is the danger that they will lose their status in the community. But TBAs can act as a link between the health facility and the community, especially to refer women. For example, in Dodoma, TBAs are paid a fee when they refer a client.

In some areas, TBAs are marginalized. In other areas there is emphasis on raising TBAs of danger signs so that they refer women presenting such danger signs for appropriate management at a health facility. In yet other areas, TBAs are given 10,000 Shs for referring women to a health facility in order to motivate them to refer women.

Even if a woman attends ANC, it does not mean that she is tracked through to delivery, or followed-up beyond this. Many women attend only one ANC visit.

Under the Hati Punguzo scheme, ITN vouchers are given to pregnant women to get ITN from shops that are registered. The women pay 500 Shs. In Mbeya city, mobile phones are used to register the clients who then access the nets from the registered shop owners.

8.2 Drugs Shortages: HIV testing

There is a countrywide shortage of Nevirapine. One health worker told us:

"One mother cried because the whole reason she accepted to be tested for HIV was to protect her child from HIV and she pleaded with me to tell her an alternative source for Nevirapine so she could use her money to buy it she was so disappointed that we failed her. During the earlier days of this shortage we went to Baylor clinic where they gave us a little supply which didn't last long. We also sourced from the referral hospital but now we cannot continue begging from these facilities as it's a long-standing problem".

8.3 Out-of-Pocket Costs

There is a lot of out-of pocket expenditure for delivery in health facilities. These OOP costs include: transport costs; sometimes pregnant women are requested to buy note books when the health providers have run out of registration cards etc.; payment for gloves ad good nursing care etc.. Fears around security and travel at night affect women's choices about whether to deliver at a facility. Lack of transport for drugs also means that certain vaccines are not available in HFs, so women may have to buy them – alongside other drugs – from the pharmacies.

8.4 Health Promotion

Where community health workers exist, they conduct sensitisation and health promotion to increase access to RCH services.

More health promotion is needed because health facilities are facing challenges in trying to meet their targets for FP. Often, leaflets are given to clients when they visit ANC, FP etc., yet there is need for training guidelines for community health workers to ensure integrated service delivery and IMCI. CHWs also mobilise the community on Vit A supplementation, water and sanitation RCH services.

8.5 Adolescent Health

The school health programme involves nurses going to schools to give TTV vaccine, health education talks on RH, dangers of teenage pregnancy, STIs and infectious diseases in general, addressing misconceptions concerning TTV etc. However, in some areas, visit are infrequent and a real connection with the school is not established.

Out of school adolescents are not much targeted. In general, services for adolescents are not specially tailored to suit their needs and concerns. The services are offered in the same way as they are offered to adults.

8.6 Men's Participation

Male participation is being promoted, but there is a challenge in ensuring that men participate in all components of MNCH. So far, the few men who participate do so to get tested through PICT or PMTCT. Men do not participate in ANC visits except, sometimes, to escort pregnant woman to a health facility.

Men and women are encouraged to come to health facilities for testing during ANC visits, and when a woman comes for ANC without a partner they are requested to bring a letter from the village chair-person, who then provides the reason why the woman failed to bring her partner for ANC.

8.7 Access and Quality of MNCH

Immunisation of children is considered the biggest achievement.

Some women's perceptions that care in the facilities is poor, stops them from delivering at appropriate health facility. Many women do not want to deliver at a referral hospital because they live far away, or they have other children to take care of at home, or they do not think that the services are of good quality at the referral facility. In some places, transfer to hospital is prohibitively far – e.g. in Ileje, with some people living more than 40 kms from hospital services. If they are not convinced that the hospital services will be good, they will not pay the OOP costs, or take the (possible) security risks to go there.

Owing to limited space in the maternity ward at Rungwe hospital, women who have delivered are often released early, even if they have had Caesarian section. There are often cases where 3 pregnant women are placed on one bed, especially women treated under CHF. In Rungwe, a conference hall was converted into a labour ward, but the challenge is that there are no sluicing rooms no toilets and no water. This seriously compromises the quality of services offered.

In Rungwe district, most of the population is within the 5Km radius distance to an HF. However, approximately 10% is out of the 5km radius. Rungwe district has a plan to use MMAM to construct 4

dispensaries which will translate into increasing service coverage to about 95% (but when will this plan be carried out?).

8.8 Family Planning

Long term FP methods are offered by NGOs, while the health providers mainly conduct health promotion for their use. When enough potential clients have been identified, the NGOs are informed and go to the health facility to provide the long term contraceptives. Health providers from the public facilities do not acquire skills in providing long-term contraceptives and complain about the lack of skills transfer. There is a question provision of long term contraceptives is sustainable in the absence of NGOs. According to the NGOs, one NGO, Engender Health, is responsible for training on long term contraceptives, while PSI staff is responsible for providing the service in the public health facilities. There is need for harmonised delivery of the training element, and of the provision of the contraceptives.

8.9 IMCI

There is very little awareness of IMCI in Bujela Utale. There has been neither additional training nor refresher training in IMCI other than that which providers received during their college training. Some providers were, however, aware of the guidelines on how to manage ill children.

8.10 Leadership

Despite the issues, there is great opportunity to improve MNCH because of existing strong leadership at central level.

9. Governance

9.1 Participation

MMAM expansion has been planned with the involvement of LGA structures (Ward Development Committees and LG Councils). PPP consultations provide a platform for harmonisation of private providers' in planning. Extending the PPP arrangement to the district has begun (advocacy for district PPP fora started at the just concluded Regional Health Forum).

HFGCs and CHSBs have been established and are used in pushing CHF advocacy forward. Participation of some members of CHSBs in the Regional Health Forum is positive. However, the HFGC and CHSB have limited ability to identify and list exempt individuals at community-level.

9.2 PPP through Service Agreements

There are challenges in Management and financing of Service Agreements (SA) – SAs have not been reviewed since they were introduced despite guidance to put into practice tangible PPP through the SAs tool; and there is no regular monitoring of implementation. The RHF recommended that 'staff secondment' be maintained to support implementation of SAs.

The RHMT made a remark that the governance area has been slow in implementation because it has not been funded all along.

10. Social Welfare and Social Protection System

10.1 CCHP Budgets and Financing

Review of the CCHPs for the districts showed tht SW is severely under-resourced. For example, in 2010 -11, in Mbeya City Council, SW received only c. .435 % of the total budget of 6,427, 474,097 (lower than the 1% SW Dept. receives of national health budget).

The following table, extracted from the CCHP, demonstrates this.

Table 3: Priority 6: Strengthen Social Welfare and Social Protection Services:

	CHBG	BG	C Sh	R in kind	Council	OTHERS	MOH/CD	NHIF	CHF	Cap	SSI	Tot
Adolesc SRH	0	0	0	0	0	0	0	0	0	0	0	0
Mat.Condit inc. infert, rape, FGM	0	0	0	0	0	0	0	0	0	0	0	0
MVC care	3,250,000	0	0	0	0	0	0	0	0	0	0	3,250000
ECD	0	0	0	0	0	0	0	0	0	0	0	0
Rehab support	2,206,000	0	0	0	11,000,000	0	0	0	0	0	0	13,206,000
Injuries/trauma	0	0	0	0	12,000000	0	0	0	0	0	0	12,000000
Mental health	0	0	0	0	0	0	0	0	0	0	0	0
Drug and subst abuse	0	0	0	0	0	0	0	0	0	0	0	0
Totals	5,726,000				23,000000							28,726,000

As elsewhere in the country, Mbeya is almost entirely dependent on external funding (through vertical, donor programmes, and NGO/FBO/other CSO engagement, for SW activities.

The SW department is unable to provide operational budgets, and Council and local level health committees do not have sufficient focus on social welfare activities (unless supported by external agencies) reliably to include SW within their budgeting. This is critical as, in Mbeya 50+% of the population and poor and vulnerable.

10.2 Staffing for Social Welfare

From the City Council we learned that Social Welfare Officers have been employed, through MOHSW, for only three years. Since this is a new initiative, their full mandate within the health sector has yet to be clarified. In local authorities, SW sits within the Community Development cluster and SWOs say that is difficult to get SW issues onto the agenda.

In Mbeya City there are 8 SWOs and there is at least one in every district (except Momba). They are based in health facilities.At least one SWO (Ileje) was, formerly, a Community Development Officer. She has been given SW training and transferred to MOHSW. This offers good opportunities in the

future to a) embed SW within the health services, b) stimulate further cooperation with the Ministry for Community Development. At regional level, a senior SWO sits on the RHT.

In Igawilo, during the meeting with the Mbeya City SWOs, Igawilo SWO and an Igawilo (SW-trained) volunteer, staff stated their needs as: transport; dedicated budget; training, updates and guidelines (CPD). These needs extend across Mbeya.

Lack of Operational Budgets

Effectiveness of staff is limited by the lack of operational budgets. This means that a) new work cannot be initiated, b) there is practically no outreach work, c) there is no case follow-up.

In Igawilo, SWOs said they sometimes go out to do baby-weighing with the EPI programmes (so that they can get transport). If they find an underweight baby, they refer to the HF – but they have no idea whether the mother ever takes the child, and they have no possibility of following up the case.

10.3 Understanding of Vulnerability and Identification of Vulnerable People

HSSP focuses on identification of vulnerable groups. However, identification of vulnerable people in Mbeya is patchy. Generally, identification should be done through the ward level councils – but they have little training and experience is this. PACT is beginning work in the region. It is contributing to implementing the National Costed Plan of Action for MVC; building capacity of local government to address MVC issues. In essence this involves implementing guidelines on identification of MVC and their families, and (through WORTH) improving income generation through credit and savings groups.

Ward level committees (the executive) are also responsible of extremely poor people and all older people over 60. Both HF staff and citizens say that this system does not work well – some people who deserve to be identified may not be, and some who do not, may slip through. However, as some staff stated, identification of over 60s could be done through voting registers. Eventually, the new birth registration campaign (witnessed at Ibaba) will make age-identification much easier.

A member of staff said: “It is a challenge for the poor &vulnerable to get access to health services. The policy is clear but the question is where to get the resources to support these groups. Unfortunately these groups consume most of the resources. They are often sick and need health care. Identification of the poor and vulnerable is done at community level but experience shows it is not often realistic some are not very poor. We rely on a letter from the executive officer and there is no other means of verification”.

Confusions over identification, and the focus on vulnerable groups alone, has led to resentments in communities and in services. In Rungwe, we were told by staff that, in their opinion, older people should not all be exempt from payment as some were perfectly able to pay. Blanket exemptions, they said, leads to reduced money to fund services.

The focus on groups can aid targeting – but medical thinking misses life pathways and misses at risk young people (especially as there are few dedicated adolescent services – in Igawilo, SWOs said they offered youth services, but when questioned, they could not say what these were, except two visits to schools this year).

10.4 Access and Exemptions

All health facilities were found to be following policy guidelines on exemptions (pregnant women, under-fives, PLWD, over-60s etc.).

In Rungwe, there is a separate building for the over-60s, with registration, waiting and treatment areas. This was considered by some staff and citizens to be unwarranted favouritism.

In Ileje, the district hospital has recently refurbished the walkways so that there is easy wheelchair and walking access. The PLWDs group stated that this, and the preferential treatment they receive at the registration window, has made access easier. They pointed out, however, that they have to travel to the RH for specialised treatment and, for secondary schooling, go away to boarding school.

In Rungwe, staff said that the walkways are unsuitable and that PLWDs rely on their relatives to carry them into the facility and the wards.

In district hospitals and health clinics, long queues were observed. Some women complained that: "if you have money, you will skip the queue and be seen more quickly".

10.5 HIV and Testing

Not all SWOs have a strong understanding on HIV and testing. In Igawilo, PICT is practised, but SWOs are unaware of any guidelines any guidelines on counselling. They said that they use the knowledge they got in college. PICT started in 2010. The SWOs think it is good, but that their counselling is not adequate.

BOX 1: PICT, Igawilo

The SWOs told us that a breast-feeding women had been found, when pregnant, to be sero+, but she was scared and didn't want to tell her husband. 6 months after the birth, she wanted to stop breast feeding, but husband wanted her to continue. The SWOs counselled her to tell her husband that she was positive, but she did not want to. She never came back and they don't know what happened.

11. Community linkages

11.1 Health Service, Community Links

The relevant committees and boards have been established in the districts – but they are not functioning well throughout. Rungwe was cited as an example of good practice. In Ibaba relevant community-level committees are involved in securing water for the maternity ward and monitoring the CCHP. In other areas, citizens' participation and understanding was patchy – partly because they lack skills and partly because they are not reliably called upon by services.

In Ibaba, the Ward Executive Chair said that the committee approves the facility plan and budget. When asked what that actually meant, it seems that the executive reviews the plan and accept it. The chair acknowledged that they have few skills or information with which to make any major challenges to health plans presented to them.

In all areas, people complained of the lack of transport and sitting allowances – "incentives" – which would encourage their full participation in governance committees. They also said that what they plan, is never what actually receives budgets.

In general, communities do not appear to feel they have active voice or influence over health services. Services are mis-trusted because of lack of drugs, doctor absenteeism, staff attitudes, waiting times, OOP costs etc. Citizens, and some local level staff, were unclear about what committees exist where (eg. Whether the MVC village level committee is separate or part of the HIV/AIDS committee). Few committees established/operating effectively at village levels.

11.2 Equitable service promotion

Some efforts are being made to promote service users' rights but full guidelines are not being followed.

There should be a complaints procedure, with complaints box, in place in every facility. In Rungwe, we saw wall posters (in KiSwahili) giving a number to call if there was a complaint. Also in Rungwe, in one treatment room, we saw a hand-written patient's charter – in English.

From conversations, it seems that citizens, whilst willing to voice complaints have no expectations that this will lead to service improvement.

11.3 Conclusions

Currently, citizen-service engagement is not working well. Citizens are involved, but the involvement is not optimised or effective.

Expansion of a range of services at community level could be a) a great encouragement to effective citizen involvement b) increase equity and access for the poorest and most vulnerable people.

12. Environmental Health

Solid waste management and water source protection were reviewed.

Mbeya was the second cleanest city in Tanzania. It is now the third (said to be because of broken-down equipment, see below).

12.1 Achievements

The department identified several things of which they are proud:

1) Prevention of communicable diseases (no cholera) – through health promotion and taking action against pollution violations – lack of latrines, dumped waste and sewerage etc.
2) Improved hygiene, sanitation and hand-washing (WASH)
3) Health education in facilities whilst people are waiting; ward level meetings on sanitation
4) Managed to protect water sources – prohibiting livestock and stopping agriculture and hunting. 20,000Tz sh charged per cow found in protected area, per day – then the cow is sold
5) Bye-law on solid waste requiring neighbourhood cleaning and removal of waste to collection point
6) Public toilets (private enterprise) at market (all flush, no biogas, no other ecological solutions)
7) Community organisation around sanitation

12.2 Challenges

1) Dump-site—though there is now Chinese investment making a modern landfill (however, currently, communities of poor and vulnerable people are living in direct line of wind-blown polluted smoke from spontaneous waste combustion).
2) No proper abattoir
3) No school toilets for children living with disabilities
4) Issues over the 2011 bye-law. They introduced a charge of 10,000 Tzsh per month for waste collection, per household. But politician said to reduce this to 5,000 Tz sh.

12.3 Water Source Protection

The water source visited in Mbeya city was well-managed and the source well protected. Two technicians were seen to be operating. A green belt has been planted to protect the source and good efforts are made to prevent people moving livestock through the area or hunting.

12.4 Solid Waste Management

12.4.1 Collection System

In neighbourhoods, garbage is collected by households and brought to a collection point, where it is collected by the council and removed to the dump-site. CSOs may now be involved in collecting to the collection point. All points are open (whether concrete or skip). Despite regular collection, many were observed to be over-flowing, surrounded by dogs, children, flies etc.

12.4.2 EH Staff

There are 88 cleansing staff and 8 drivers. It was observed that the health status of these workers is likely to be severely compromised by their work. They do not have full (any) protective clothing, no gloves or masks, inadequate brushes, shovels etc.. Solid waste removed by hand includes semi-liquid and rotting food matter, sharp objects etc..

12.4.3 Workshop and Equipment

The EH department of MCC is housed in the same yard as the MCC offices. The yard contains a "workshop" (earth floor, open sides, no tool placement areas, poor stores) and a collection of defunct and dying vehicles.

Mechanics were seen to be working hard to keep vehicles functional, but the facilities are totally inadequate. Of 2 skip-masters, only one was operational. There are also 4 side-loaders and 2 tippers (one grounded). There are 2 sludge-gulpers (which charge 60,000 Tzsh per trip per household). But staff were not able to say how often a household would need to have the pit emptied.

There are 27 EHOs: restaurants, licencing, health education etc.. Each is responsible for a ward

12.5 Sanitation

MCC claims to be higher than the 62% regional average coverage with latrines. However, these are not all improved. Public (privately run) market toilets appeared to be in good order.

Cleansing Day has been introduced on every last Saturday of the month. No business is allowed to open until their frontage and nearby areas is clean.

12.6 Conclusions on Environmental Health

There have been some notable achievements, but many, serious, challenges remain. We noted that, if Mbeya is the second cleanest city, then all those behind it in the league must be filthy indeed. In MCC, as elsewhere, solid waste services are fighting against very difficult odds. The whole collection system needs re-thinking. A proper workshop and vehicle store needs to be constructed – away from other offices. At present, the filthy collection vehicles are a health hazard to all MCC staff working out of the yard. There are no proper workshop facilities, no proper vehicle washing facilities and no proper staff washing facilities. Health promotion is being expanded to communities – but environmental health staff, including cleansing workers are working in internationally unacceptable conditions.

As elsewhere, there are good opportunities to operate EH services in ways which include cost recovery. This should contribute to service improvement, but needs careful checks and oversight to prevent mal-practice and to ensure equity of access, even for poor and marginalised people.

13. Feedback to the RHMT

A very brief feedback meeting was held of the end of the visit. 14 RHMT members and co-opted members attended.

The team highlighted the limitations facing Social Welfare and Social Protection and encouraged the RHMT to continue their efforts for enhanced community sensitisation, advocacy and education on issues around CHF/NHIF, vulnerability, inequalities in access to services and reaching at-risk and vulnerable individuals in communities.

The environmental health implications of the current waste disposal situation were noted. It was agreed that the refuse disposal system in the city is under-resourced. However, the achievements in protecting water sources and providing improved drinking water were also noted.

On systems strengthening, several issues were highlighted including the need to have a determined effort to enhance HR management practices, improve data reliability, analysis and information use, achieve more efficient management of procurement (to address stock outs effectively) as well as to have in place more analytical oversight on medicines and supplies (to prevent pilferage). Conflict of interest in managing and auditing ADDOs is an area that needs further attention.

13.1 Other Issues:

- The need to give greater focus to quality of services, with particular emphasis on availability of critical MNCH supplies and medicines, was underscored.
- Strengthening PPP efforts through reviewing existing Service Agreements and enhancing understanding of PPP at districts was seen as well-conceived.

  The Regional Health Forum (RHF) was seen as a valuable initiative for information sharing and mutual stimulus for enhanced performance in the region. It is a useful coordination mechanism, and experience sharing platform: with improved group dynamics and participatory techniques more could be harnessed from the experiences of participants.
- The Region aired a concern that should be taken to higher level: the confusion caused by closure of District accounts (to 6) that has had negative impact on CHF. The 6 accounts introduced by PMORALG make it difficult to get statement of accounts.
- Limitations posed by the single Blood Bank serving Mbeya, Iringa, Njombe, Ruvuma, Rukwa and Katavi Regions, were also noted.

14. Conclusion

There is a need to strengthen the role of the RHMT in assessment of CCHPs, so as to ensure that plans are based on solid evidence. Greater attention needs to be given to ensuring that interventions planned are based on local priorities, and that the planning is not "cutting and pasting" from the previous year.

The following challenges that emerged require systemic solutions:

- Recurrent limitations in availability of essential medicines and supplies from MSD, and bureaucratic local procurement of items missed from MSD.
- Regional Health staff (professionals) coverage stands at 55% (on average). Gap closure efforts should be intensified.
- Limited functionality of the referral system.
- Quantified investment in Adolescent-friendly sexual and reproductive health, post-abortion care, BEMONC, post natal care for mothers and newborn, early new born care and resuscitation, nutrition/ malnutrition, is difficult to determine precisely within the CCHPs. Technical analysis of CCHPs should pay more attention to these priorities.
- Concrete actions against Gender Based Violence are lacking except for advocacy events.
- How to address budget gaps when Donors fail to honour their pledged funds. Enhance the RHF process through wider sharing of information on those that have honoured their pledges.
- Gaining greater understanding of the social determinants of health in the area, identification of vulnerable people etc.
- Securing dedicated budgets to address vulnerability and inclusion issues at all levels (e.g. making sure social welfare is budgeted in CCHPs).
- Managing issues around economic access to services among exempt categories of people.
- Addressing why facility deliveries decreased in some health facilities
- Quality and quantity of supervision at dispensary level and how to enhance it with a mentoring approach.

14.1 Recommendations:

1. The MOHSW plans for RHMTs capacity building should aim at imparting good quality supervision skills, including mentoring and analytical skills.
2. Mbeya RHMT should consider improving the process of the Regional Health Forum through mapping and responding to participants' expectations, and use of more interactive techniques for optimal participation, will harness the different talents that this innovative forum would bring together.
3. Besides CCHP and meetings, other management practices are not strongly enforced resulting in demoralised health workers, poor quality of service delivery, poor customer care and client

expectations for medicines not been met. The RHMT and CHMTs should direct HRH Focal Persons to enforce standard HR management practices in all Councils' health work places.

4. The CHMTs in collaboration with RMHT should double their efforts to accelerate closure of the 55% HRH gap.
5. The MOHSW should make a clear plan for strengthening the ZHRC including providing it with funds so that it can fulfil its in-service capacity-building function, Schools monitoring and other essential functions on CPD and accreditation of schools.
6. Availability of medicines and essential supplies at Health facilities should be given higher attention by CHMTs and the RHMT through close monitoring of functionality of ADDOs, putting in place measures to break the conflict of interest experienced by ADDO operators, researching ways to cut down on bureaucratic procurement and making their local measures and proposals known to higher authorities (MOHSW).
7. Improve health promotion for four or more ANC visits
8. Address stock outs of drugs and supplies especially for MNCH.
9. Ensure adolescent reproductive health is one of the focused areas.
10. The RHMT needs to work closely with DED/PMO-RALG to ensure that district and ward level committees understand the importance of correct identification of vulnerable people and are able to allocate resources to meet their rights and needs, with equity. In Mbeya region, there is a distinct advantage of having the new PACT involvement.
11. To stimulate community enthusiasm for participatory planning, there needs to be better information flow from region through to district and ward level, on government priorities and agendas. Greater transparency on what service challenges can increase community trust. Communities can unite around single-issue programmes – such as the vaccination and birth registration linkage, or by linking CHF enrolment to school enrolment.
12. There is urgent need to a) improve the workshop and yard facilities for solid waste management vehicles and equipment; provide washing facilities and remove the site from the vicinity of other offices; b) improve the health and safety of sanitation workers (provision of uniforms, gloves, washing facilities etc.); c) improve cleanliness around collection points and ensure that they are not a health hazard, particularly for children.

Annex 1: List of Persons Met

	Name	Position
1.	Dr.SeifMhina	Regional Medical Officer
2.	Ms Juliana Mawalla	Regional Health Secretary
3.	Dr. Gloria Mbwile	MO i/c
4.	Dr. Paulina B. Mbezi	Ag Regional Aids Control Coordinator
5.	Ms L.M. Mbembela	Regional Nursing Officer
6.	Ms Grace Ngailo	Regional Continuing Education Officer
7.	Ms MargrethMtokambali	Regional Eye Coordinator
8.	Mr. Jordan Nyenyembe	Regional Mental Health Coordinator
9.	Mr. Johannes Schweda	Development Advisor GIZ-TGPSH
10.	Ms AikaTemu	Regional Social Welfare Officer
11.	Dr.YesayaMwasubila	Regional TB and Leprosy Coordinator
12.	Ms Anna J. Otaru	Matron
13.	Ms Paulina Nsyenge	Accountant
14.	Mr. Peter L. Meleki	Regional Health Officer
15.	Dr. Frederick A. Minja	Technical Advisor – GIZ TGPSH
16.	Ms Lucia F. Mkumbo	Regional Pharmacist
17.	Dr. Agnes Buchwa	Regional Dental Officer
18.	Dr. Julius E.A Sewangi	RACC
19.	Mr. Joseph Mwakasonda	RCHFCo
20.	Dr. Abel Asilia	RNTDCo
21.	Ms PriscaButuyuyu	RRCHCo
22.	L.F. Mkumbo	RPharm
23.	Mr. Philip Mwaisobwa Productive sctor).	Regional Veterinary Officer (Asst RAS Economic and Ag. RAS
24.	Dr. Lazaro	City Medical Officer of Health, Ag. City Director
25.	Dr.Mbuya	City Medical Officer, Mbeya City
26.	Dr.Sungwa Ndagabwene	DMO
27.	Mr.SolfenNjeleka	DHS
28.	Mr. Nimrod Kiporoza	DEHO
29.	Mr. George Mgala	HO and CHF Coordinator

30. Mr. Patrick Kibopile — Pharmacist
31. Mr. Emanuel Mwashambwa — Soc Welfare Officer
32. Mr.Danford Barnaba — DIVO
33. Mrs Magret Chitanda — DRCHO
34. Mr.Lusubisyo Mwasongwe — HMIS, Ag Health Secretary and Dental Officer
35. Miss Elizabeth Maembe — Soc Welfare Officer
36. Ms. Omega Ikupa — SWO
37. Ms.Adetruda Mpongoliana, — Volunteer SWO
38. Ms. Victoria Lunanilo, — SWO
39. Bupe Joel — CSWO
40. Mr. Julius Tweve — Nursing Officer in Charge
41. Ms. Emakulata Palula — Nursing Assistant
42. Mr. Ferick Jackson Mgeni
43. Mr. Kasera Nundu — PACT
44. Ms. Atusumege Emma Kubetta — PACT
45. Mr. January Ndunkguru — EHO
46. Mr. Odas N. Aron — Acting Head of Cleansing MCC
47. Mr. Msomba Uswege — EHO
48. Dr. Christopher Jakoracha — Ileje
49. M. Labay Nyakuru — CDO
50. Mr. Tatamsaleghe Kibona — Hon Chair WE, Ibaba
51. Mr. M. H. Diwani, WE — Ibaba
52. Mr.Lyson H. Habonga, WE — Ibaba
53. (Members of the Disabled Persons' Group, Ileje)
54. Mr. Paul Gogo — GIZ

Annex II: Field Visit Activity Schedule

Table 4: Activity Schedule of HSSP III MTR Review Field Visit to Mbeya

Date	Activity	Place	Time Spent And Travel Time
Saturday	Arrival, detailed planning of the site visits	Hill View Hotel	Afternoon
Sunday 21st	Reading reports, site seeing	Mbeya City	Afternoon
Monday 22nd	**Day in Mbeya** Courtesy call RMO, and to RAS Discussion with Mbeya City CHMT and other stakeholders and Conducting field visits to Health facilities Discussion with Regional Heath Management Team (RHMT) and Hospital visit	One Night in Mbeya	08:00 am - 09:00am 9:00 am to 13:00 14:00 to 16:00 pm
Tuesday 23rd	**Travelling** Travelling from Mbeya to Rungwe		07:00 am – 8:00 am
Tuesday 23rd	**Day in Rungwe** Discussion and field visit to health facilities in Rungwe DC	Rungwe DC	08:30 am – 16:30 pm
Tuesday 23rd	**Travelling** Travelling from Rungwe to Mbeya		16:30 pm – 17:30 pm
Wednesday 24th	**Day in Mbeya** Facility vistsctd, environment in Municipality and Zonal Resource Center	One night in Mbeya CC	08:00 am – 16:30 pm
Thursday 25th	**Travelling** Travelling from Mbeya to Ileje DC Attending Regional Health Forum		07:00 am – 9:30 am
Thursday 25th	**Day in Ileje** Conducting meeting, discussions and field visit to health facilities in Ileje DC	One night in Ileje DC	10:00 am -18:00 pm
Friday 26th	**Travelling** Travelling from Ileje To Mbeya Attending Regional Health Forum		08:00 pm – 10:30 pm
Friday 26th	**Finalisation** **Any pressing remaining field observations** Afternoon finalization		10:30 to 13:00 14:00 to 16:30
Saturday 27th	Team compilation of field findings and Debriefing meeting with RHMT **Travelling** Return to Dar es Salaam		8:00 to 10:30 11:30 am