All Councils in the country were instructed by the President of the United Republic of Tanzania to have functional Council Health Service Boards (CHSBs), by 31st December 2004, which shall be responsible to oversee the management of health services in their respective Councils.

The CHSB is a Board established by the Act of Parliament No.7 and 8 of 1982 which instituted Local Authorities. It comprises of 11 members: 7 being elected representatives of the community and 4 members being technical staff, from the office of the Municipal/District Executive Director, the Council Hospital and Regional Health Management Team (RHMT). Only the elected members have the right to vote, for decisions needing a majority ruling.

Besides the CHSB, there shall be established health facility and ward governing Committees, to monitor health services at facility and ward level.

The CHSB is composed of the following:

- Chairperson of the Social Services Committee of the Council
- District Medical Officer, who becomes the Secretary of the CHSB.
- Representative of the private for profit service providers
- Representative of the non-profit service providers
- Representative from the RHMT
- 4 representatives elected from the users of the health services, two of whom must be women; and one member from this group becomes the CHSB’s Chairperson.
- 2 technical staff from District Executive Director’s office, namely:-
  - District Planning Officer / Economic Planner
  - Representative of the Council Hospital

Roles and Functions of the CHSB:

Section 86 A and 52 A of the said Law, empowers the Local Authority to establish the Community Health Fund (CHF) which shall be managed by the CHSB. The CHSB will also:-

1. To collaborate with Council Health Management Team (CHMT) to ensure delivery of quality health services in the Council
2. To recommend to the Council on CHF exemption criteria
3. To ensure a steady membership enrolment of the CHF

Status of implementation at Council level:

By the 31st December, 2004, only 49 CHSBs were inaugurated and 109, out of 114
Councils country wide, had signed bylaws to introduce CHSBs.

Encouragingly, out of 49 operational CHSBs, 3 were from Morogoro Region namely Ulanga, Municipal and Morogoro Rural Councils; and among 109 Councils that had their bylaws signed to introduce CHSBs, included Kilosa and Kilombero Councils. This was a tremendous achievement for the people of Morogoro.

Unfortunately, Kilosa had already established a Board since 1999 and had collected over Tshs.72,000,000/- from the CHF, but it was instructed to re-establish its Board according to the laid down procedures, to legalize its existence. Among other anomalies, it was found that:-

1. Kilosa CHSB was being chaired by the Chairperson of the Social Services Committee of the Council.
2. The Board was established before the instrument had been signed by the Minister for Local Government and Regional Administration as stipulated by the law.

The Way Forward:
While the bottlenecks in Kilosa are being streamlined, and have their CHSB legally reinstated, other Councils in the Country are being encouraged to visit Morogoro and learn from our achievements, in the introduction of CHSBs and listening and responding to the Community Voice.

Mr. Mankambila, JCD
Regional Health Secretary
Morogoro
Dear esteemed readers, on behalf of the Editorial Board of this Newsletter I would like to welcome you to the Fourth Issue which covers events and issues for the period of July 2004 to June 2005.

The Board would also like to thank readers who submitted articles to be published in this issue. We apologize for failing to accommodate in this issue all articles submitted by our readers. Rest assured that those articles which were not published in this issue have been preserved in safe custody for subsequent publications.

We equally salute readers who sent in comments on the third issue; the valuable comments have been used in the improvement of this issue.

The Board would like to inform our readers that Mr. C. Kakwaya, the Board member who was also the District Health Secretary for Kilombero Council, was transferred to Dodoma as a Regional Health Secretary (RHS). He has been replaced by Mr. Dia Ally Dia who was the Ruvuma RHS. The Board welcomes Mr. D. A. Dia and commends Mr. C. Kakwaya for his contribution to the Board’s deliberations.

Health services delivery in Morogoro Region and the country as a whole has taken a remarkable stride where the main beneficiaries have been empowered legally to manage the services. Four District Councils in Morogoro Region namely Municipal, Ulango, Kilombero and Morogoro Rural have inaugurated Council Health Service Boards (CHSBs) and Committees. The CHSBs and Committees facilitate and monitor health care delivery by observing some of the following:

- Proper management of the health services
- Sensitizing communities on enrolment to the CHF
- Participating in planning of health services at health facility level
- Sourcing for finance options for strengthening health delivery

Lastly we request our readers to submit your comments and articles for inclusion to subsequent publications.

Dear readers, the Board regrets that, due to unavoidable circumstances, this issue could not be published on schedule.

Mr. N. Masaoe
Chairman
Editorial Board
ESTABLISHMENT OF HEALTH SERVICES BOARD
IN MOROGORO MUNICIPAL COUNCIL

The establishment of the Council Health Service Board (CHSB), Health Centre Committees, and Dispensary Committees in Morogoro Municipal Council was done in conformity with the Local Government Act No. 7 and 8 of 1982 Section 52A and the Council’s bylaw of 2002.

The inauguration of the CHSB was done in a colorful ceremony on 28th September 2004 after a 3-day training of the CHSB and Committee members which was done by officials from the Ministry of Health.

As required by law, the inauguration was conducted by the Morogoro District Commissioner Mr. Mathew Sedoyeka and was also attended by the Lord Mayor of Morogoro Municipal Council Hon. Francis E. Kayenzi, Deputy Mayor Hon. Mohamed Lukwele, Honorable Councilors, the Municipal Director Mr. A.P. Mageka and Acting Regional Medical Officer Dr. Ritha Lyamuya. Also Heads of Departments and Ward Executive Officers of the Morogoro Municipal Council attended.

The inauguration of Health Centre / Dispensary Committees was done in February 2005 marking the completion of an important step towards practical, active and effective community participatory health planning and supervision.

Three Health Centre Committees were inaugurated, which were Sabasaba, Mafiga and Uhuru. In addition, four Dispensary Committees of Kingolwira, Towero, Mbete and Konga were also inaugurated. Thus all health facilities run by the Council were covered.

As stipulated in the law, the inauguration of the Committees was conducted by the Lord Mayor who was accompanied by members of the CHSB, the Municipal Medical Officer of Health and other officials from the Council.

During these ceremonies, the Lord Mayor congratulated those who had been elected to serve in the Committees.

He also advised them to abstain from internal squabbles and concentrate on implementing their duties effectively by representing the wishes of those who elected them into office so that, through them, the people can participate in the planning, supervision, implementation, and in making other health decisions pertinent for their health development and survival.

He reminded them to adhere to the instructions given to them during their training which was conducted immediately after their election/nominations to the Committees. He also told them that they will be responsible for ensuring that quality health services are delivered within their localities.

Lastly he reminded the community members of their responsibilities in as far as health issues are concerned and requested them to give maximum cooperation and assistance to the Committees.

Mr. E. Rugiga
Clinical Officer, Mafiga RHC
Municipal - Morogoro
COUNCIL HEALTH PLANNING TOOLS

Morogoro/Mvomero District Council like all Councils in Tanzania mainland, annually carry out Comprehensive Council Health Planning (CCHP). In order to conduct effective CCHP, Councils deploy some of the following planning tools, which were developed by Tanzania Essential Health Intervention Project (TEHIP).

The tools include:

**District Burden of Disease Profile**

Any plan should be evidence based, so according to this phenomenon, the Council uses this planning tool which shows District Burden Diseases. Resources are allocated accordingly. The burden of disease is obtained from Sentinel District Demographic Surveillance System, which monitors at households level of all migrants, births, deaths and cause of death.

**District Health Expenditure Mapping**

This tool facilitates distribution of resources equitably. It is taking in account Burden of Disease (BOD) and other important intervention such as Integrated Management Childhood Illnesses (IMCI), HIV/AIDS etc. The computerized programme used along beside this tool is known as District Health Accounts Matrix (DHA).

**District Cost Information System**

This tool is used as for cost effectiveness analysis. This tool assists in technical efficiency by providing the CHMT with annual feedback on the patients / case costs of essential health interventions at individual health facilities (Cost Centre or Level according to Prototype Documents).

**Community Voice**

As planning should be evidence based, the Participatory Action Research (PAR) is one of the effective methods to collect community based data as evidence. PAR reflects Community Voice. Community Voice is also important to identify community’s preferences toward health services. It helps to develop community based strategies, which will lead to increase health service utilization and users’ satisfaction.

These tools help the Council in resource allocation according to the burden of disease, prioritization of the problems to their CCHP even to show the expenditure during the implementation according to funds allocated.

Dr. M. Omari
District Dental Officer
CHMT – Mvomero

THE TREND OF TUBERCULOSIS CASES IN KILOSA DISTRICT

Kilosa District is the largest district of Morogoro Region, with the population of 502,225 (2002 Population Census). Kilosa ranks the second on tuberculosis (TB) cases notification in the Region. In 2004 there were 712 cases of all types of TB notified. Morogoro Municipal has the
highest number of TB cases in the Region, where 1,277 cases were reported during 2004.

The high incidence of TB cases in Kilosa could be attributed to the following:

- Poverty leading to improper housing and nutritional status
- High prevalence of AIDS
- Early treatment seeking behavior of TB clients, which facilitate early case detection
- Adequacy of resources for TB diagnoses and management

Pulmonary TB is a disease caused by Acid Fast Bacilli called Mycobacterium tuberculosis. Other bacilli such as Mycobacterium bovis and Mycobacterium africanus are responsible for causing extra pulmonary TB.

The causative organisms of pulmonary TB are transmitted through droplet infections, when patients cough, sneeze or talk in open without due caution. Extra pulmonary TB is transmitted through consumption of infected cattle products such as meat and milk.

Control of TB will include the following measures:

- Early case detection and proper management
- Vaccination by BCG antigens of all newborns
- Living in properly ventilated houses, and without overcrowding
- Proper feeding of under fives and those at special risk
- Sensitisation of the community of the mode of transmission and effective control measures
- Proper inspection and pasteurization of meat and milk for human consumption

The trend of TB cases in Kilosa for the past 5 years is illustrated in the diagrams below.

### THE INTEGRATED MANAGEMENT CASCADE

Integrated Management Cascade (IMC) is designed to promote further autonomy, decision making, advocacy and involvement of the district health facilities and promoting arrangement of all Frontline Health Workers (FLHWs) toward the implementation of activities of the district health plan and Health Sector Reform (HSR).

The broad objective of the IMC is to facilitate a functional arrangement hierarchy below the CHMT in order to facilitate distribution, supportive supervision, training, referral and monitoring of health facilities service areas as well as maintain maximum communication among health facilities and the district headquarters.

Logically it was impossible for the CHMT to implement effectively supportive supervision in
all 98 health facilities in the District, due to limitation of resources especially manpower and time. Despite implementation of HSR and creation of CHMTs, communication and involvement of FLHWs in HSR have been minimal.

To address the above constraints, in 1998, the CHMT formulated IMC, so as to delegate some of the CHMT functions to Health Centres. The delegation empowers the Health Centres to supervise Dispensaries within their service areas.

To improve implementation and communication, each Health Centre has been equipped with a radio call, a motor cycle, and an ambulance. Skilled personnel has also been assigned for each Health Centre. The CHMT has a radio call and a mobile radio for the vehicle of district head office.

IMC activities are the following:

- Supervision and training in malaria control activities, Integrated Management Childhood Illnesses (IMCI), sexual transmitted infections, TB and leprosy control
- Distribution of drugs, equipments and Insecticide Treated Nets (ITNs)
- Communications, community voice, rehabilitation of health facilities and staff houses using community labor-based approach
- Collection of ITNs’ sales, Health Management Information System (HMIS) reports, and indent system drug order forms
- Referral of patients
- Facility level analysis of HMIS data, supply of HMIS tools, indent tools and inventory of equipments
- Liaise with the district headquarter on staff social issues, arrangement of local staff allocation and annual leave

Benefits realized by IMC system include:

- Establishment of Cascade Node laboratories which cater for satellite dispensaries
- Initiation of bottom – up planning process by using Participatory Rural Appraisal
- Management of finance after establishment of the Council Health Service Board and health facility Committees
- Implementation of National Health Campaigns such as Vitamin A, measles, and SNIDs
- Soliciting resources from the community

In order to sustain and strengthen the IMC, the following will be done:

- More capacity building to Cascade Supervisors
- More advocacy at all levels on IMC system
- Provision of communication facilities such as radio calls to all eligible health facilities to enhance communication and referrals

The success of the IMC system in Morogoro Rural Council has been appreciated at all levels and has attracted visitation from other districts within and without the Region. All are welcome to visit the IMC system in Morogoro Rural.

CHMT - Morogoro Rural
CARTOON
GIVE FIRST PRIORITY TO COMMUNITY HEALTH FUND AT YOUR HOME
Author/Drawing: Mr. J. Bundu

ANNOUNCEMENTS

• Our esteemed readers, we invite views and suggestions on a name you deem suitable for this Newsletter.

• Also we invite your contribution of articles to be included in the Newsletter for the next issue due for December 2005: the articles should be related to health or opinions and suggestions on how health services are rendered in Morogoro Region and are not to exceed 400 words.

Articles or letters to the Editor should be sent to the following addresses:-

- The Editor Morogoro Health Newsletter
  P.O.BOX. 110, MOROGORO
- or, P.O.BOX. 1193, MOROGORO FAX 023 - 4148

or, Could be sent to the respective District Medical Officer or Municipal Medical Officer as follows:-

- P.O.BOX. 166, Morogoro Manispaa
- P.O.BOX. 1862, Morogoro
- P.O.BOX. 14, Kilosa
- P.O.BOX. 47, Ifakara, Kilombero
- P.O.BOX. 4, Mahenge, Ulanga

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